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Self-reported stress sources and personal problems among psychotherapists

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SELF-REPORTED STRESS SOURCES AND PERSONAL PROBLEMS AMONG PSYCHOTHERAPISTS

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Self-reported stress sources and personal problems among psychotherapists

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INTRODUCTION[a]

The mental health of psychotherapists is instrumental in their work. It has been asserted theoretically that the therapist's mental and emotional well-being is a foundation of her/his craft (Cassimatis, 1979; Strupp, 1958; Whitfield, 1980). Clear perceptions and uncontaminated reactions are associated with mental health and are the therapist's tools. The therapist is advised to be objective about the client and about the therapist's own subjective responses to the client. That is, when the therapist does experience disproportionate emotional reactions and/or when conflicts or prejudices cloud his/her perceptions, the therapist is expected to be aware of these occurrences and to deal with them separately from the client's session. Do therapists in fact maintain positive mental health?

One factor affecting therapists' mental health may be occupational stress. It is commonly believed that psychotherapists work under a great deal of stress. "Doesn't it depress you to hear all those problems every day?" is a question often encountered by clinicians. In fact, therapists are confronted daily with the troublesome conflicts of other people as well as suicide threats, psychotic behavior, and

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[a]This research project has been approved by the Iowa State University Human Subjects in Research Review Committee.

criminality. As one therapist pointed out in a discussion of the stresses of psychotherapeutic practice, "If one wayward child can impair the morale of a whole family, it therefore stands to reason that ten disturbed patients are going to take their toll on the therapist" (English, 1976, p. 197). What are the stresses for therapists at work?

These questions about therapist mental health and therapist stress are as yet unanswered in the professional literature. The stereotypes and myths about therapist mental health and stress exist, while the research is minimal (Cherniss, 1980; Farber, in press). Therapists have been systematically studied only recently in regard to these issues, and a coherent, definitive body of data has not yet emerged. The study described herein was an attempt to contribute to the growing store of data.

In general, occupational stress in helping professions typically has been viewed from the perspectives of where the stress originates (sources) and how it is exhibited by individuals under stress (symptoms). Once sources and symptoms are identified, stress treatments or prevention tactics are suggested for change at the agency level, for facilitation of co-worker cooperation, and/or for relief from personal distress.

Other models for analyzing stress phenomena include

stress consequences, adaptation responses, and process and time variables (Beehr & Newman, 1978; Cooper & Marshall, 1976; Perlman & Hartman, 1982) in recognition that stress is developmental and cumulative and should be studied multidimensionally. Similarly, Cherniss (1980) encourages "holistic" developmental process studies as a way of integrating the individual/organization variables. For example, he believes that novice professionals as a group react differently from experienced professionals to external (i.e., agency-based rather than intrapsychic) stress within the same organization. Longitudinal studies would reveal the crucial events in the change in stress reactions between the newcomer and the expert. Cherniss also notes the exploratory nature of stress research in the helping professions since patterns in the data are not yet evident or are only beginning to be apparent.

In order to gain perspective on psychotherapist stress, a model is constructed for conceptualizing and examining stress within the population of interest. For studying therapists, either internal or external stressors can be targeted in work and non-work spheres of the subject's life. Individual characteristics, such as a "driven" or Type A personality, are internal (intrapsychic) factors which can affect components of both the non-work and work

areas. In the general job stress literature it is recognized that individual characteristics of a worker (the internal factors) as well as events in the worker's personal life (external, non-work factors) interact with employment conditions (external, work-related factors) in creating a stress syndrome (Cooper & Marshall, 1976; Kobasa, 1979; Pardine, Higgins, Szeglin, Beres, Kravitz, & Fotis, 1981).

Since the concern of the proposed study is with psychotherapists as members of a particular profession, only the work sphere will be investigated. The specific focus is on stress sources, both internal and external, in the context of work (professional role, work setting, and actual in-session client contact). Internal or intrapsychic factors that may be relevant to stress in the therapist's work life are the therapist's personality, the therapist's mental health, and countertransference. Definitions, rationale, and review of literature pertaining to these broad factors are presented in the following portion of this paper. Next, similar consideration is given to the external (or situational or environmental) factors relevant to therapist stress in the same realms of professional role, work setting, and client sessions. Then a study is presented which addresses the questions: How stressful are

certain specified experiences for therapists in sessions and in the professional role? How stressful are certain beliefs which therapists may hold? What are the mental health problems of therapists?

LITERATURE REVIEW

Research and discussion articles relevant to the topic of therapist stress are reviewed following this general outline:

I. Intrapsychic factors in therapist stress
   A. Therapist personality: The ideal therapist
      1. A-B therapist types
      2. Rogerian conditions
      3. Other characteristics of the ideal therapist
   B. Therapist mental health: Disorders among therapists
      1. Incidence rates of disorders
      2. Mental health measures and correlates
      3. Therapist-induced client deterioration
   C. Countertransference
II. Situational factors in therapist stress
   A. Occupational stress in helping professions
   B. Therapist stress
      1. Discussions of therapist stress
      2. Studies of therapist stress

First, an overview of the literature on the ideal therapist personality is presented in order to provide the rationale for including the therapist's state of well-being in investigations of the therapeutic process. Studies

of therapist mental health then are surveyed briefly along with incidence rates of various psychological disorders among psychotherapists. Therapist mental health as an independent variable in studies of therapy process and outcome, and related topics of pathogenesis, mental health of trainees, and client deterioration are included. Of particular importance to understanding the feelings of the therapist is the phenomenon of countertransference, defined broadly as the therapist's conscious and unconscious perceptions of and emotional reactions to the client (Freud, 1937/1964). Works relevant to the topic of therapist stress are introduced.

The literature pertaining to situational factors is reviewed second, including stress in training, occupational stress in the helping professions, and therapist stress. The research design is then described for the study of psychotherapists regarding sources of stress and incidences of psychological disorders and problems among therapists.

Intrapsychic Factors in Therapist Stress

The personality or style of the therapist is significant in therapy. As Hans Strupp wrote in his 1958 article on the therapist's contribution to the therapy process,

> ...it is clear that therapeutic techniques are not applied <u>in vacuo</u>, and that they are differentially

> affected by factors in the therapist's personality. His performance is determined - in part, at least - by the way in which he perceives the patient's behavior, interprets its meaning in the framework of his clinical experience and his own personality, and the way in which this meaning is reflected in his response (Strupp, 1958, p. 35).

The traits which make up an individual's personality can be viewed as internal (intrapsychic) characteristics, and they can be sources of potential stress. Good mental health is difficult to specify but is closely tied to concepts of a therapeutic personality or the ideal therapist (Cassimatis, 1979). In client sessions, mental health of the therapist is inextricably bound to the countertransference phenomenon.

Therapist personality: The ideal therapist

In order to recognize that stress and poor mental health can affect a therapist's performance, it may first be helpful to investigate the ideals for psychotherapist behavior. If an ideal therapist type were identified, it could serve as a standard for judging real therapists' styles and for further investigation of the "ideally healthy" therapist.

Two related lines of research in the 1960s were zeroing in on therapist behaviors in sessions with clients in attempts to discover the winning combination of therapist traits. One line of work was initiated by Whitehorn and

Betz when they differentiated between therapists who were and were not effective with hospitalized schizophrenic patients (Whitehorn & Betz, 1954). The so-called A and B therapist types proposed by Whitehorn and Betz were investigated and discussed at some length (McNair, Callahan, & Lorr, 1962; Swenson, 1971; Whitehorn & Betz, 1960) but the early promise of a way to match therapist types with the diagnostic categories of patients with which they would be most successful has gone unfulfilled. Major reviewers have concluded that the A-B variable may be associated with therapist personality type but has not been demonstrated to have a significant correlation with therapeutic success (Lambert, Bergin, & Collins, 1977; Razin, 1977).

Another popular area of research into therapist personality was stimulated by Carl Rogers, whose ideas generated a flurry of research in the 1960s and early 1970s. A fundamental ideal typology was suggested by Rogers when he proposed the well-known necessary and sufficient conditions for therapeutic change, which included the therapist qualities of genuineness or congruence, empathy, and positive regard of the client (Rogers, 1957).

In his 1966 review of psychotherapy research, Bergin equated the Rogerian notion of therapist congruence with the healthiness shown by the therapist in session with the

client. Likewise, Foulds concluded that "a positive association may exist between psychological well-being and ability to communicate facilitative conditions during counseling" (Foulds, 1969, p. 132), and Swenson, in a 1971 review of the Rogerian conditions research, concluded that these facilitative behaviors of the therapist were significantly related to progress in therapy (Swenson, 1971). More recently, similar but modified claims have been made about the roles of congruence, genuineness, and empathy as therapist characteristics (Parloff, Waskow, & Wolfe, 1978; Strupp, 1977) although it is noted that the originators of these concepts had stated earlier that other therapist characteristics were important also (Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, & Stone, 1966).

Attempts also have been made to associate various levels of the Rogerian conditions with therapist mental health as measured by the Edwards Personal Preference Schedule (EPPS) (Bergin & Solomon, 1963) and the Minnesota Multiphasic Personality Inventory (MMPI) (Bergin & Jasper, 1969), and to interrelate the conditions themselves (Garfield & Bergin, 1971a). At this point, the majority opinion seems to be that the necessary and sufficient conditions generally are desirable but are not as powerful in and of themselves as was originally believed (Lambert, DeJulio,

& Stein, 1978; Swenson, 1971), and what impact they do have may occur more in client-centered than in other types of therapy (Bergin & Jasper, 1969).

Meanwhile, other characteristics of the therapist have been found to relate to therapeutic success. For example, Strupp, Fox, and Lessler (1969) studied 76 former patients of 11 therapists and found that the therapist qualities of attentiveness, interest in the client, warmth, and "doesn't arouse anger" were related to therapeutic success as determined by both therapist and patient ratings. Swenson (1971) reviewed earlier work on the personality of the therapist as related to therapeutic effectiveness, and he concluded that valuable characteristics were interest in people, originality, self-insight, warmth, integrity, and self-control. Frank (1974) added "healing power" and charisma to this continually growing list.

In 1950, Fromm-Reichmann wrote on the diversity of desirable therapeutic characteristics, and stated that the best fit of therapist, client, and presenting problem could not be specified in a single, general therapist type (Fromm-Reichmann, 1950). In 1958, Holt and Luborsky agreed that no "therapeutic personality" could be identified for successful therapists of the 218 psychiatric residents that they studied (Holt & Luborsky, 1958). Meltzoff and

Kornreich's review (1970) echoed earlier assertions that no single therapeutic personality could be specified.

The findings of research stimulated by the A-B typology and the Rogerian conditions; the speculations on the ideal therapist personality; and the investigations of differences between effective and ineffective therapists have not led to a coherent picture of a single, ideal therapist type. In all likelihood, a single ideal cannot be conceived which would apply to all therapy settings, for all clients.

Therapist mental health: Disorders among therapists

Despite the lack of agreement on an ideal profile or constellation of traits that make up the prototypic effective therapist, there remains a widely-held belief that at the very least the therapist should be free from severe mental or emotional disturbance. A variety of writers agree that the therapist's emotional and mental ill health, regardless of degree of severity, probably will have some negative impact on the client, making therapy less effective (Bergin, 1966; Bergin & Jasper, 1969; Freud, 1937/1964; Knutsen, 1977; Parloff et al., 1978). Presumably, disturbance could be a transitory state resulting from time- or situation-limited stress, or it could reflect long-standing patterns of maladaptive behavior on the part of the

therapist. Even mood fluctuations or conflicts that fall within the normal range of human experience may influence the therapist's competence in sessions. Too often this point has seemed so obvious to therapists that it goes unstated. There is an assumption among professionals that how accurately they are perceiving their clients is in part a function of their own existing mental/emotional well-being and has a crucial impact on their therapeutic effectiveness.

There are some limited data on incidence of various disorders and treatment among therapists. Data on suicide and alcoholism among psychiatrists reveal that 15% of physicians who kill themselves are psychiatrists although only 7.8% of certified M.D.s are in the psychiatric specialty (Knutsen, 1977). Likewise, psychiatrists make up 17% of physician members of Alcoholics Anonymous (Knutsen, 1977). Figures for psychiatric residents are somewhat more available, possibly because this group of psychiatrists is more readily accessible for research than are certified physicians. It has been estimated that 2 to 4% of all residents terminate their professional training because of emotional disturbance (Garfinkel & Waring, 1981). Incidence rates of disturbance range from 9 to 16.5% of all residents, while over half of psychiatrists in training enter personal

psychotherapy or psychoanalysis (Garfinkel & Waring, 1981).

In their survey, Henry, Sims, and Spray (1971) found that 74% of mental health professionals had themselves been in therapy for at least one session. As might be expected, this varied markedly between professional groups, with 41% of the clinical psychologists reporting that they had been clients in more than one therapy contact contrasted with 26% of psychiatrists, 52% of psychoanalysts, and 30% of psychiatric social workers. These figures are misleading as a gauge of therapist mental health, however, because a large proportion of therapists entered therapy for professional rather than personal reasons (e.g., 41% of the psychiatrists and 15% of the psychologists).

Diagnostic data for psychologists are much harder to find than for psychiatrists. Clayton, Marten, Davis, and Wochnik (1980) studied 257 women M.D.s and Ph.D.s from various fields including psychology and psychiatry. The incidence of major affective disorders was higher among these highly educated women than among the general female population, but rates for psychiatrists and psychologists did not differ significantly from each other or from other professional specialties. The Diagnostic and Statistical Manual of Mental Disorders (DSM III) (American Psychiatric Association, 1980) gives 18 to 23% as the incidence range

for major affective disorders in the population at large, and at least one study using the diagnostic criteria which serve as the basis for the DSM III found a rate of 26.7% for women and men combined for both major and minor depression (Weissman & Myers, 1978). However, Clayton et al. (1980) found that one-third or more of their sample of professional women fell into the major depression category. They note that this is consistent with the common and related finding that professional women have a higher suicide rate than women in general, although this is confounded with other variables known to be associated with both suicide risk and the lifestyle of the professional woman, such as marital status.

Regarding suicide among psychologists, Mausner and Steppacher (1973), in a comprehensive investigation of all suicides and suspected suicides among American Psychological Association members in a 10-year period, found that the rate for female psychologists greatly exceeded the expected value, while the rate for male psychologists actually was less than expected. The expected values were derived from general population suicide statistics. Mausner and Steppacher's results reflect the overall higher rate of suicide for men compared to women, and the higher rate for women in professional jobs compared to women in general. Neither

the Mausner and Steppacher nor the Clayton et al. study differentiated psychologists practicing psychotherapy from psychologists in other specialties.

Of course, poor mental health or stress in the therapist may be manifested more subtly than in suicide or major depression. Fiedler (1950) hypothesized that experienced experts in the therapy field were less swayed by their own needs and were more in control of their insecurities than were non-experts. Some researchers have explored the relationships between therapists' performance and the less obvious indicators of psychological disturbance. In a unique study by Arbuckle (1956), counselor trainees were asked which of their fellow students they would most like and least like as their own therapist. Those students chosen most as the desired counselor had scale scores on the MMPI in the normal range while those rated as least desirable tended to have several scores above the norm (>70), suggesting that the "least desirable" students were unhealthier than the "most desirable" ones.

Anecdotal accounts have been written of therapists' own experiences and/or emotional difficulties and how these affected their work. Norman Endler (1982) has published a book on his own manic-depressive illness, and Kirschenbaum (1979) wrote about Carl Rogers' bout with depression.

Others have shared how their own families, marriages, illnesses, and friends' deaths affected them and their professional work (Anonymous, 1978; Chernin, 1976; Cray & Cray, 1977; Lewis, 1982). Pregnancy in psychiatric residents was investigated by Baum and Herring (1975) as a personal therapist stressor. The interaction between professional and personal stresses is chronicled dramatically in books by Schiff (1970) and Barnes and Berke (1971). Therapists under personal stress unanimously concede that their behavior at work is somehow altered during times of personal or non-work crisis.

Wirth's findings on therapy outcome as related to personality test scores of counselors in training supported the contention that mentally healthy therapists are more effective than unhealthy therapists with a wider variety of clients (Wirth, 1973). Other studies have shown that healthy therapists as determined by the MMPI Ego Strength scale secure greater client change than do unhealthy therapists (Garfield & Bergin, 1971b), and that therapist repressiveness correlates negatively with therapeutic outcome (Wogan, 1970), although Mihalik (1970) noted a positive association between therapist neuroticism and client improvement. At least one writer has suggested that the abnormal therapist may be preferable for schizophrenic

clients (Krebs, 1971).

It is a popular belief that individuals who want to be therapists are disturbed to begin with or at least are selecting this particular profession in an attempt to work out their own problems. There is no sound evidence that this is the case nor is it clear how such research would be conducted (Matarazzo, 1978). Despite this, it has been suggested by Bergin (1966) that positive mental health of the therapist is such a crucial ingredient for effective therapy that trainees should be selected in part on this basis. Bergin argues that we should assume that a disturbed therapist cannot perform adequately unless and until we acquire evidence to the contrary.

Henry et al. (1971) surveyed 243 psychotherapists concerning their original motivations for entering their field, and found that a larger percentage of the clinical psychologists as compared to psychiatrists and psychoanalysts cited the desire to "understand and help myself." The authors noted that this apparent difference between professionals may be confounded by other differences, such as the earlier developmental and chronological age at which individuals decide to enter medical school versus a psychology program. At any rate, this tells us nothing about psychotherapists as a group contrasted with non-therapists.

An early attempt to predict trainee competency from results of Rorschach assessments of students was largely unsuccessful (Abel, Oppenheim, & Sager, 1956). Recent meaningful research is difficult to find. While surely this is a concern for the responsible psychology department graduate admissions committee, there appears to be as yet no reliable way to discern which applicants will make competent therapists based on pre-training personality.

Before one can speculate on whether poor mental health among trainees is a cause or effect of their choice of profession, the existence and extent of disorders among trainees should be documented. Statistics on the incidence of various symptom syndromes are available for psychiatric residents. For example, Garfinkel and Waring (1981) found that 10 of 60 residents could be classified as disturbed or possibly disturbed based on scores from the General Health Questionnaire (GHQ), which screens for non-psychotic emotional illness. However, baseline data for pathology in psychology graduate students are difficult to pinpoint. Thus, while it is evident that serious disturbances can exist among therapy trainees, hard data for psychology trainees are scarce and figures remain unconfirmed.

Psychoanalysts and therapists from other orientations have written of the desirability of personal growth

experiences for students in order to complement their professional growth (Foulds, 1969). Retrospective views of counseling psychologists seem to support this contention, as surveys by Rachelson and Clance (1980) and Billingsley (1978) demonstrate. Billingsley followed-up 167 guidance and counseling education graduates from a major university and concluded that continued strong emphasis on personal development of students was one of the graduates' primary concerns. Similarly, Rachelson and Clance (1980) surveyed 192 American Psychological Association (APA) Division of Psychotherapy (Division 29) members regarding their attitudes toward the 1970 APA standards for psychotherapy training, and they found support for "enhancement of personal growth" and "personal therapy" to be included in training.

Other counseling professionals claim that students learn to appreciate the value of using their own feelings to facilitate therapy as a result of experiencing the client role in their personal therapy (Ralph, 1980), and that personal therapy for trainees leads to decreases in authoritarianism and dogmatism and an increase in flexibility (Walker, 1977). Some writers specifically recommend analytic group therapy (Grotjohn, 1969), communication training and cognitive restructuring (Tosi & Eshbaugh, 1978), and family therapy (Guldner, 1978) to aid students'

growing professional competence. Stress or burnout prevention training for students is encouraged (Warnath & Shelton, 1976), and Gallessich and MacDonald (1981) state that one benefit of the group analog training model that they promote is participants' increased awareness of needs they have which may interfere with competence as a therapist.

Despite the agreement that personal growth and therapy experiences are fundamental to the psychotherapist in training, only one-fourth of Rachelson and Clance's subjects reported that these activities had been a regular part of their curriculum (Rachelson & Clance, 1980). In response to an item asking where the therapists learned most about being an effective therapist, the most popular answers were "My practice" and "Personal therapy." And while 76% reported that personal therapy had not been required for their training, 62% of the total sample would include it in an ideal training program. A survey of 87 APA-approved clinical training programs showed that 67% "actively encouraged" therapy for trainees (Wampler & Strupp, 1976). Henry et al. (1971) questionned 243 clinical psychologists, psychiatrists, psychoanalysts and social workers regarding their retrospective views of what had been the most important aspects of their training. Personal therapy, work experience, and supervision were the most frequently named

responses, ranking ahead of formal training, faculty, courses, institutes and workshops, colleagues, and readings, among other choices.

In the area of training, there is consensus among researchers and experienced therapists that personal therapy and personal growth opportunities are valued as training adjuncts. It is less clear whether the stereotype is true that individuals who choose to become psychotherapists are less "normal" than other professionals. The evidence is inconclusive, also, concerning the relationship between trainee mental health and later competency.

The variable of whether a therapist has had personal therapy has been included in numerous studies of the characteristics of effective therapists. Presumably, a therapist who seeks therapy himself/herself is under stress or suffers from some personal problem, and as such personal therapy is a rough measure of the therapist's mental health. Attempts have been made to determine what, if any, effects the therapists' own therapy has on their competence as a counselor. Despite the theoretical and professional arguments in favor of therapists gaining some awareness of their own psyches to facilitate professional competence, few studies have shown even a small difference in the in-session behavior of therapists who have or have not had

therapy (Greenberg & Staller, 1981; Strupp, 1955, 1958). The vast majority of studies reveal no differences in therapy outcome when the therapist's personal therapy is included as an independent variable (Meltzoff & Kornreich, 1970), and no differences were found for the dependent variables of improved competency in training (Holt & Luborsky, 1958), early therapy termination by the client (McNair, Lorr, & Callahan, 1963), or therapist stress syndrome (London, 1977). At least one study showed a negative correlation between client outcome and amount of personal therapy that the therapist had had (Garfield & Bergin, 1971b). It is noted that the conditions of all the above findings may be contaminated by at least two important factors: (1) whether or not a therapist has had therapy is nearly always correlated with number of years of experience, a variable which is known to be related to therapist behavior in session (DiLoreto, 1971; Lambert et al., 1977), and (2) there is no way to determine if the pre-personal-therapy levels of adjustment of the two therapist groups were equal, e.g., therapy may have been essential to raise one therapist's competence to the level of another therapist without therapy.

VandenBos and Karon (1971) inaugurated a new term, "pathogenesis," for the therapist trait underlying unhealthy

symbiotic relationships with clients. In this type of relationship, the helper uses the client's dependency to meet the helper's needs. VandenBos and Karon expanded this term's definition from an earlier application of it to unhealthy parents of schizophrenics (Meyer & Karon, 1967). Utilizing a special scoring of the Thematic Apperception Test (TAT) which tapped tendency to exploit dependent individuals (in this case, clients), VandenBos and Karon demonstrated that pathogenic therapists could be identified with a psychological test, thus lending support to their construct. They postulated further that poor mental health in the therapist is related to poor client outcome, while positive therapist mental health is related to therapeutic effectiveness (Karon & VandenBos, 1972; VandenBos & Karon, 1971). For unknown reasons, this line of research has not been continued to the present time.

Studies of therapist-induced client deterioration are relevant to an understanding of harmful as contrasted with ideal therapist behaviors. A significant contribution was made by the Lieberman encounter group studies in the investigation of group leadership styles and client outcome (Lambert et al., 1977; Lieberman, Yalom, & Miles, 1973). This group of studies will not be discussed here, but it is noted that there are specific in-session therapist

behaviors that have been associated with unusually poor client outcome following encounter group participation.

Incidence rates of psychological disorders among therapists, mental health evaluations of therapists, attempts to define therapist "pathogenesis", and therapist-induced client deterioration studies are all different perspectives on the common theme of harmful or unhealthy therapist behaviors. Poor therapist mental health can be viewed as an intrapsychic source of stress or as a result of prolonged exposure to stress. The causal connection between stress and mental health is left unclarified at this time. The point is that how a therapist responds to professional or in-session sources of stress is a function of factors both external and internal to the therapist. The internal factors include the therapist's personality, style, and her/his mental and emotional well-being or disturbance, which may be manifested in overt, observable behavior.

Countertransference

The topic of countertransference is introduced because of its theoretical importance to understanding the interrelation between the therapist's personality and the client. Also, countertransference is another internal factor related to therapist stress, although it is by definition tied to an external factor, client behaviors in

session.

The interpersonal relationship between therapist and client has long been held to be a significant factor in therapeutic progress (Fiedler, 1950, 1951; Strupp, 1958, 1978), and countertransference is a phenomenon that both affects and is affected by this relationship. In its broadest definition, countertransference, a term first used by Freud, is the therapist's conscious and unconscious reactions toward and feelings about the client (Freud, 1937/1964; Sandler, Holder, & Dare, 1970). Countertransference feelings may include all the therapist's reactions to the immediate in-session situation with the client, or it may refer only to those feelings of the therapist triggered by the client but which have roots in the therapist's personal past (Spensley & Blacker, 1977).

Theoretically, countertransference occurs readily when some behavior of the client cues an unresolved conflict in the therapist. Thus, a therapist's response to a particular client is in part a function of how much the client's behavior resembles conflict areas within the therapist. A potential danger is that the therapist may focus on her/his own conflicts rather than the client's, and the therapist may or may not be aware of this dynamic. Countertransference can disturb patient-therapist communication

because of anxiety in the therapist, and create blind spots for the therapist where perception of clients is distorted (Sandler et al., 1970). These difficulties are most likely to occur when therapists remain unaware of their own internal conflicts (Baum, 1977; Koocher, 1980; Strupp, 1978; Whitfield, 1980; Witenberg, 1977).

The most well-known call for attention to the issue of trainee mental health is that of Freud in his recommendation that analysts undergo personal psychoanalysis while they are in training and periodically throughout their careers (Freud, 1937/1964). The primary purpose of this attention to the analyst's mental health is to focus directly on countertransference issues (Baum, 1977).

In addition, countertransference can be a tool in aiding the therapist to better understanding the client. This requires a further differentiation of countertransference feelings into those that are most appropriately dealt with solely in the therapist's therapy, and those that are useful in working with the particular client who cued those feelings. Ralph views this as a mature step in the therapist's development and writes, "The emergence of this stage in part depends on an increased sense of confidence and self-esteem in the student and a greater ability to trust his or her own reactions as a source of information

rather than an unwanted and anxiety-provoking intrusion into the therapeutic process" (Ralph, 1980, p. 247). Feelings can be judiciously shared with clients when the aim is to further the therapy goals (Epstein & Feiner, 1979; Kubie, 1971; Strupp, 1958). The very motivations that the therapist had for becoming a therapist may lie in unresolved conflicts, but this is not thought to pose a problem for therapeutic efficacy unless it interferes directly with the client's work (Greenson, 1966; Lindner, 1978).

Strupp and Bergin write that the literature on countertransference "generally says that conflicts in relation to hostility, dependence, warmth, and intimacy, etc., have an inhibiting effect upon the patient's performance in therapy" (Strupp & Bergin, 1969, p. 36). There is little direct testing of the notions about countertransference despite its importance, in part because of the difficulties of devising operational definitions of psychoanalytic concepts (Cutler, 1958; Meltzoff & Kornreich, 1970). Because of this, in clinical research countertransference often is simply assumed to exist. The handful of studies that have addressed this issue have gone unreplicated for the most part although they have been provocative and highly suggestive of what can go wrong in therapy when the client treds on the thin

ice of the therapist's neuroses. For example, Bandura, Lipsher, and Miller (1960) found that the frequency with which clients expressed hostility within the therapy setting seemed to be a function of the therapist's need for approval as well as how the therapist responded when the hostility was directed at him/her. Winder, Ahman, Bandura, and Rau (1962) uncovered a similar pattern in the area of dependency, i.e., more dependency was expressed by a client after it had been positively reinforced by the therapist. Cutler (1958) studied tapes and coded response categories for two therapy trainees and found support for his hypotheses that therapists will give distorted accounts of clients' behaviors when they are related to the therapist's own areas of conflict, and that the therapist will not perform well in those areas.

Rigler (1958) obtained evidence that the therapist's anxiety increases when she/he is listening to client material from the therapist's areas of personal conflict. Results of studies of therapist anxiety confirm the suspected negative correlation between therapist anxiety and competence (Bandura, 1956; Roberts & Bowman, 1978), although at least one researcher uncovered a negative relationship (Wogan, 1970).

Singer and Luborsky (1977) reviewed the experimental

countertransference literature and determined that there was general agreement that experienced therapists handled countertransference better than inexperienced; that the client does indeed influence the therapist; and that the therapist's attempts to avoid certain topics has a direct relationship to the frequency of expression of those topics by the client. In addition, all the discussion articles previously cited consistently support the beliefs that (1) countertransference is a source of stress for therapists, and (2) countertransference is itself affected by the therapist's general mental health.

In summary, the intrapsychic or inner sources of disturbance for the psychotherapist spring from his/her personal characteristics, general mental health, and conflicts that are aroused by in-session dynamics. These forces interact with each other as well. Beliefs remain strong about the desirability of the absence of disorder in the therapist. Where certain in-session therapist behaviors are found to be predictive of client outcome, the relation between those behaviors and the therapist's mental health remains unconfirmed. A single therapeutic personality cannot be identified. Therefore, even if mental health in the therapist could be defined unambiguously, there is reason to doubt that the hypothetical mentally healthy therapist

would necessarily be effective for the universe of clients. There is some research support for the contentions that positive mental health in therapists is associated with positive outcome among clients, and that personal therapy or personal growth experiences during counselor training enhance the mental health of trainees. What is not known is the difference in particular in-session behaviors between the healthy and the unhealthy therapist.

Situational Factors in Therapist Stress

Since no ideal therapist personality can be identified and since the mental health of the therapist has proven to be an elusive variable to define and measure, therapist stress may be a more manageable focal point within given situations. Stress responses can be conceptualized as the situation-specific behavioral manifestation of the general trait of therapist mental health interacting with situational pressures.

Clearly there is a relationship between mental health and job stress. For example, in their review of research on job stress and employees' physical and psychological health, Beehr and Newman (1978) concluded that a strong association has been shown between job stress in non-mental-health professions and personal symptoms such as tension, depression, irritation, anxiety, and "neuroticism."

Unfortunately, while the occupational stress literature is vast, there are few studies of stress among psychotherapists. Most of the rare ones that do exist are concerned with organizational sources of stress for a variety of workers at all levels within helping professions, rather than in-session sources for therapists, or stresses arising from the therapists' unique professional role. Related literature will be reviewed as it bears on the subject of therapist stress.

Occupational stress in helping professions

Occupational stress is defined by Cooper and Marshall (1976) as "negative environmental factors or stressors ... associated with a particular job" (p. 11). They add that "Inherent characteristics of the individual and his behaviors may also contribute to occupational ill health" (p. 11). Thus both internal (intrapsychic) and external (environmental) factors are acknowledged.

The term "burnout" has been coined to refer to the occupational stress syndrome which occurs among persons in the human services. Maslach (1978a) explained burnout as "the emotional exhaustion resulting from the stress of interpersonal contact" (p. 56). Continually giving to people in trouble takes its toll as the helper burns up emotional energy faster than it is "recharged"

and becomes emotionally depleted. Edelwich and Brodsky (1980) described burnout as "a progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work" (p. 14).

Burnout has been investigated almost exclusively within agencies and across disciplines, and has been treated primarily as an institutional concern. In Cherniss and Egnatios' study of 164 professional and paraprofessional staff members from 22 different mental health programs, "organizational quality" was the most frequently cited source of job-related dissatisfaction (Cherniss & Egnatios, 1978). The organizational characteristics variously cited as responsible for staff burnout are: excessive workload, ambiguous or ineffective lines of authority, separation between policy-making power and responsibility to implement decisions, dealing with life and death or other crisis situations, inadequate facilities and personnel due to limited budgets in the social services, excessive paperwork, lack of immediate performance feedback, large patient-to-staff ratios, and rigid work schedules, in medical clinics and hospitals, prisons, welfare offices, legal aid offices, social service departments, schools, mental hospitals, psychiatric wards, nontraditional agencies, and free clinics

(Cherniss, 1980; Cherniss & Egnatios, 1978; Cherniss, Egnatios, & Wacker, 1976; Edelwich & Brodsky, 1980; Freudenberger, 1974, 1975, 1977; Hall, Gardner, Perl, Stickney, & Pfefferbaum, 1979; Maslach, 1976; Pines & Maslach, 1978, 1980). The human symptoms of organizational burnout range from high employee turnover and absenteeism to personal complaints of physical illness and fatigue as well as psychological and behavioral indications of depression, irritability, alcohol abuse, depersonalization, intellectualization, and physical and emotional distancing from recipients of the service. All of these studies focused primarily on external, organizational contributors to stress.

Cherniss' 1980 book titled Professional Burnout in Human Service Organizations presents a comprehensive discussion of the burnout research to date. He formulated specific research questions with which he attempted to differentiate the institutional and individual stress factors: What are the sources of stress for social service workers? How do workers cope with stress? How does coping lead to attitude and behavior changes? How does the work setting influence the change process? Cherniss selected novice professionals as his target group, and he conducted two to four interviews with each of 28 professionals, with less than three years' experience each, in publicly-funded

agencies. His sample of lawyers, nurses, teachers, and other human service professionals included six social workers and one school psychologist. Due to the exploratory nature of the Cherniss study, open-ended and relatively unstructured interviews were used rather than a structured, laboratory format. For the same reason, variables were not predefined but were allowed to arise from the data. Results showed several points evident across disciplines: bureaucratic interference with personal and professional goals was a major cause of burnout for new professionals; isolation from others in the profession was a stress source; and initially high idealism and unrealistic expectations on the part of these professionals were predictive of later burnout.

Cherniss' study is important because of the thorough conceptual analyses and integration of his findings. He writes in a coherent and common-sense manner about the major themes that he identified in his interview material. He conducted a systematic study of a small group of professionals, and provided a model for this type of holistic, exploratory study. However, the sample, although small in number (N = 28), was heterogeneous with respect to professional discipline, and no psychotherapists were included.

Streepy (1981) examined symptoms of burnout in social

service providers (primarily Master's-level social workers) in family service agencies in an attempt to correlate burnout with certain demographic and agency factors. She reported a number of bureaucracy-related factors accounting for some of the burnout (e.g., centralized decision-making and poor intra-agency communication). She also noted a direct correlation between burnout and amount of stress provided by the client population but concluded that sources of stress work in combination with each other, with no single environmental or demographic variable being solely responsible for burnout. Agency variables were the point of interest in Streepy's work.

Maslach has been involved in several studies of burnout among helping professionals (Maslach, 1976, 1978b; Pines & Maslach, 1978, 1980). She discusses the client factors that may contribute to burnout among social workers, ward attendants, therapists, and other personnel (Maslach, 1978b). She notes particularly that the type and severity of client problems, and the empathy or even the over-identification that is triggered in helpers are major sources of stress. Also, the deleterious effects of bureaucracies are evident; in this case, the rigid and mechanized set of rules that often govern institutional handling of clients. Maslach argued that high expectations of staff

combined with low expectations of clients result in an untenable burden of responsibility on staff and a perpetuation of dehumanizing attitudes toward clients.

The work of Maslach and associates previously cited has been an impetus for further study of therapist stress. However, again it is noted that agency sources of stress are targeted and the population of interest is mixed in regard to occupation.

External burnout remedies advocated by investigators have been: development of better work time management, non-work hobbies, restriction of job work to on-the-job hours, involvement with family, professional growth and development activities, informal peer support, and better clarification of the professional role (Boy & Pines, 1980; Freudenberger, 1974; Freudenberger & Robbins, 1979; Maslach, 1976, 1978b; Pines & Kafry, 1978).

All of the studies mentioned above center on human service workers in public agencies. Other studies have found no difference in burnout between public and private mental health employees (Daniels, 1974; Justice, Gold, & Klein, 1981). However, Justice et al. (1981) did find that of 188 staff in mental health settings, public employees rated overall work satisfaction lower than did private workers, and the latter reported more positive life events

outside of work. The data also suggest that work burnout is more likely for a particular individual when stressful circumstances are present both in and outside work.

Therapist stress

Most non-experimental discussions of profession-related stress for psychotherapists come from psychiatric practitioners or observers of psychiatrists (English, 1976; Freudenberger & Robbins, 1979; Greben, 1975; Kubie, 1971; Rogow, 1970; Schlicht, 1968; Whitfield, 1980; Will, 1971). These writers share the belief that psychotherapy is a hazardous profession, and they agree that the hazards, or stress sources, stem from the professional role and social expectations associated with psychotherapy as well as from the very nature of client work. Sources of stress which recur in these discussions are as follows:

Professional identity

1. social expectations for therapists to be perfectly well-adjusted themselves in their personal lives;
2. stereotypes of therapists as constantly "analyzing" people and having no personal life;
3. interdisciplinary rivalries between physicians,

psychiatrists, psychiatric social workers, and psychologists;

4. isolation from other professionals, particularly for the private practitioners;
5. the professional ambiguity of psychotherapy as an art/science/craft.

Client work

1. daily exposure to problems and disturbances of clients, including acutely psychotic clients and clients who need help with interpersonal skills and are, simply, difficult to get along with;
2. dealing with the unpredictable but relatively frequent occurrences of crises in the lives of clients (e.g., client hospitalization or commitment, suicide threats, divorce, incest, etc.);
3. client hostility toward the therapist, resistance to change, and premature termination;
4. emotionally draining experience of therapeutic intimacy with clients;
5. stimulation of personal conflicts within the therapist as a result of working with a client and the bottling up of the therapist's feelings

during client sessions;

6. maintaining an emotionally empathic but objective stance with clients;
7. sustained, focused attention on the needs of others;
8. the therapist's grandiose desires to feel omnipotent, in control, and important to the client;
9. termination with a client after a close relationship has developed over time;
10. the slow pace of therapeutic progress.

Special client populations can contain additional stress sources for the therapist, For example, Doernberg (1980) cites the frustrations of working with mentally retarded individuals, who will never be fully functioning in a normative sense. A pediatric cancer ward forces the therapist in that setting to confront the powerlessness of children as well as the emotions stirred up in the patient, the patient's family, and the therapist related to the impending death of a young family member (Koocher, 1980).

Only a handful of studies have been identified which deal directly with therapist stress. Two of these are descriptions of therapy groups composed of therapists. Kline (1972) participated for over a year in an

eight-member leaderless group of psychoanalysts, and he reported that the members' common concerns relating to their careers were professional isolation and loneliness, and the analysts' grandiose and self-depleting attempts to be parents to their clients. Similarly, McCarley (1975) described the oppressive and overwhelming responsibility that therapists said they felt in working with psychiatric patients. McCarley's observations occurred during short-term, intensive groups provided for therapists. He concluded that depression probably occurred for many therapists at mid-life, after years of doing therapy and confronting their own countertransference issues, and when a personal and professional revitalization was needed.

Other researchers in the past decade have surveyed therapists in order to determine stress sources and symptoms. One such work was Daniels' study of 152 psychiatrists working in private practice and in institutions (Daniels, 1974). Daniels used 18 incomplete sentences to elicit attitudes about psychiatric practice. Sample stimulus items are "One thing you never get in psychiatry is ..." and "It is important to be the kind of psychiatrist ...." Responses were classified and tabulated in an effort to identify common sources of stress. Daniels found no significant difference between the concerns of private versus

organizational practitioners. Problems mentioned by two-thirds or more of the respondents were isolation from other psychiatrists, the personal strain involved in doing therapy, the arrogance and unfriendliness of other psychiatrists, doubts about treatment effectiveness, and status worries.

Bermak (1977) used a written questionnaire to query 75 psychiatrists, most of whom were private psychotherapy practitioners, about special emotional problems they might have. In response to the question "Do you think that psychiatrists have emotional difficulties that are special to them and their work as contrasted with non-psychiatrists?", 68% replied "yes." Most of those answering affirmatively attributed those emotional difficulties to the nature of the psychiatrist's work, although over half also cited the personality of the psychiatrist as contributing significantly to emotional problems. Another question posed by Bermak requested respondents to describe the special difficulties that exist for the psychiatrist. Professional isolation was the most common response, given by 38 of the 75 psychiatrists. Having to control one's own emotions in sessions with clients was mentioned by 21. Omnipotent wishes and subsequent frustrations, ambiguity of progress determination, emotional drain of being constantly empathic, confusion and conflicts of professional identity, and "the

obsessive-compulsive personality structure" of many psychiatrists were each noted by ten or more of the sample.

Bermak's open-ended responses are surprisingly similar to Daniels' results, despite the differences in format and wording of the stimulus materials. That is, in both the Daniels and the Bermak studies professional isolation, emotional strain in sessions, the perceived problems of other psychiatrists, and doubts about therapeutic progress emerged as the greatest stressors.

The stresses of professional isolation, constant demands for attention, and a degree of powerlessness with clients were cited as the most negative aspects of doing therapy in a study by London (1977) using a large sample of psychiatrists (249), clinical psychologists (221), and social workers (316). London also found that private practitioners cited these particular stresses significantly more frequently than did agency employees. No correlations occurred between type of stress reported and average weekly number of work hours, client contact hours, years' experience, or whether the subject had had personal therapy.

Forney, Wallace-Schutzman, and Wiggers (1982) chose to work with a small sample of career development professionals because of their interest in the individualistic and multifaceted nature of stress among helping professionals rather

than concern with statistical generalizations about burnout. In interviews, 24 subjects were questionned in the major topic areas of job content, work environment, the work-nonwork relationship, self-awareness, and energy level (or burnout). The causes of burnout or the sources of stress were of less interest to Forney et al. than were the symptoms and coping strategies that were used to combat debilitating stress. The familiar burnout symptoms showed up in this sample, and the researchers identified certain trends. First, they found that burnout symptoms tended to be an exaggeration of normal behavior, in either direction of too much (work, involvement, hyper-reactivity, etc.) or too little (caring, decreased efficiency, etc.). Neither pattern was conducive to client growth. Second, symptoms could be psychological, physiological, and behavioral. And third, a snowball effect was produced when emotionally depleted and fatigued individuals continued to work and to become increasingly more vulnerable to routine stresses. On the basis of their findings, the researchers inferred that burnout can occur as a trait phenomenon, a short-term situational condition, or a temporary activity-based state, and that burnout is influenced by intrapsychic as well as external events.

A unique contribution of the work of Forney et al. is

their application of Rational Emotive Therapy to understanding intrapsychic sources of stress. Following analysis of interview transcripts from their 24 subjects, they concluded that there are common irrational beliefs subscribed to by therapists that would appear to fuel the tendency toward professional burnout. They presented the following as the most common irrational beliefs in their sample:

My job is my life.

I must be totally competent, knowledgeable, and able to help everyone.

I must be liked and respected by everyone with whom I work.

Other members of my agency do not appreciate the value of career counseling, and should be more supportive.

Getting any form of negative feedback indicates that there is something wrong with what I am doing.

Because of past failures, things will not work out the way they should.

Things have to work out the way I want.

An association was detected between the presence of burnout for an individual and whether she/he truly believed many of these helping profession myths. Forney et al. stated

that "One interesting finding was that not one of these career development professionals disputed all of the myths. Even when an interviewee dealt very well with several of the myths, he or she was inclined to have difficulty with another. Those participants who subscribed to the greatest number of irrational beliefs tended to be the ones who were burning out" (Forney, et al., 1982, p. 438).

The latest study to address psychotherapist stress is by Farber and Heifetz (1982). Sixty psychiatrists, social workers, and psychologists agreed to participate in interviews focusing on stresses and satisfactions of psychotherapeutic work. The therapist sample was unevenly represented by psychoanalytic therapists (40 of the 60) and by institutional (41) rather than private practice (17) therapists. Results of interview transcript analyses revealed that 73.7% cited "lack of therapeutic success" as their primary stressor, and 57.4% blamed "non-reciprocated attentiveness, giving and responsibility demanded by the therapeutic relationship" as major causes of burnout.

Farber also reported additional findings from a stress rating scale which supplemented the interview (Farber, 1978). Of the 24 stress items which subjects rated on a 7-point Likert scale, excessive workload, difficulty working with patients, organizational politics, emotional depletion,

responsibility for patients' lives, and constant attentiveness were seen as moderate or greater stress sources. A second scale contained 25 patient behaviors to be rated according to how stressful each was. Suicidal ideation, aggression and hostility, and premature termination averaged as moderate or greater stressors, compared to relatively low stress patient behaviors of missed appointments and threats to terminate therapy.

Examination of the scales used in the preceding study revealed several weaknesses in the written stimulus materials (Farber, 1978). The statements of client behaviors to be rated by the therapist for stress were not equal in precision or concreteness. That is, some items contained general diagnostic or theoretical terms (e.g., compulsive behaviors, defensive intellectualizations), others were simply vague (hypersensitivity), while others were specific and behavioral (lateness, phone calls at your house). "Apathy and depression" was listed unexplainably as one item. Given the absence of precedent for Farber to work from in creating his scales, the ambiguities are understandable.

Summarizing the studies of stress among therapists, several points are evident: (1) the number of studies addressing therapist stress is quite small; (2) psychiatrists were the sole subjects or the majority of subjects

in most studies; (3) subject numbers generally are small; and (4) most of the studies used responses collected from open-ended or vaguely worded stimulus items. Given these methodological limitations, findings to date support the following as major non-organizational sources of work stress for therapists: (1) professional isolation; (2) overwhelming feelings of responsibility for clients; (3) doubts about treatment progress; (4) emotional strain; and (5) demands for attention.

Present Study

The present study investigated internal and external sources of stress for therapists. The purpose of this investigation was threefold: (1) to confirm and further specify some sources of stress for therapists already speculated upon and described in the literature; (2) to expand the knowledge about intrapsychic contributors to therapist stress; and (3) to collect data on incidence rates of various psychological problems and disorders among psychotherapists.

Since the typical study of stress among helping professionals deals with a variety of workers in agencies or institutions, this study followed the recent trend toward greater population specificity and, therefore, involved only individuals whose primary professional identification

was that of psychotherapist rather than, for example, caseworker or ward attendant. Psychiatrists and psychiatric nurses were not included here in an attempt to add to the meager store of information on non-medically trained clinicians.

The research focus on organization-based stresses has generated a list of bureaucratic and policy ills that, not surprisingly, are found to contribute to employee burnout. However, studies dealing with therapists are inconsistent in their findings on stress among private versus public sector therapists. In the present study, private practitioners were included along with therapists in agencies in order to allow comparisons between those groups on non-organizational stress variables. That is, stresses arising from the professional role and from sessions with clients were targeted rather than organizational stresses.

Specific research questions addressed were:

1. What client behaviors are the most and the least stressful to therapists? How frequent are these stressors? Do stress differences exist among subject subgroups based on gender, amount of experience, work setting, educational background, number of weekly client contact hours, and form

of therapy?

2. What therapist role experiences are the most and the least stressful? Do subgroup differences exist?
3. Are there certain myths or beliefs held by therapists that are sources of stress for that professional group? Are there subgroup differences?
4. What are the incidence rates of mental and emotional disorders in this therapist population? Do subgroups differ from each other?

The study was exploratory and the data were descriptive; this is in line with the embryonic state of research knowledge in this area to date (Cherniss, 1980; Perlman & Hartman, 1982). Accordingly, no formal hypotheses were developed.

METHOD

Procedure

A mailing list was compiled of 642 individuals who seemed to meet the subject criteria of being professional psychotherapists with advanced degrees in relevant fields. The potential subjects were drawn from the following sources in an attempt to include most therapists in the state of Iowa:

1. the Resource Directory of the Community Mental Health Centers Association of Iowa, Inc. (1982),
2. the National Directory of Mental Health (Detlefsen, 1980),
3. telephone directory entries under these headings in major Iowa cities:

   Counselors
   Marriage and Family Counselors
   Psychiatric Clinics
   Psychologists
   Psychotherapists
   Social Service Agencies
   Social Workers

4. a list of all hospitals with psychiatric wards, including state institutions,
5. alcohol and drug abuse treatment center directories, and
6. university counseling center rosters.

A stress questionnaire packet was sent to each potential

subject. In some cases, individual staff members' names were not known. In these instances, a number of packets was sent to a department head or clinical director along with a brief letter of explanation which requested distribution of the packets within that agency.

Questionnaire packets were mailed to potential subjects in January, 1983, and each consisted of a cover letter explaining the study, a four-part stress questionnaire, and a stamped envelope addressed to the primary investigator for return of the completed questionnaire. Three weeks after the first mailing, postcards were sent to all subjects encouraging them to fill out the questionnaire if they had not already done so and thanking them if they had. A return rate of 40 to 50% was anticipated based on rates in similar mail surveys (Hutt, 1981; Wiseman, 1972).

Materials

Early versions of the cover letter and questionnaire were administered in an informal pilot study to ten therapists. Data were not analyzed from this preliminary run, but pilot subjects were asked to react to the letter and questionnaire with criticisms and suggestions. Many of the comments were incorporated into the materials actually used in the study. These materials are described below.

Cover letter

The cover letter for the questionnaire was typed on letterhead stationery of the Student Counseling Service, Iowa State University, over the names and titles of the primary investigator and her research supervisor. The letter explained the purpose of the study, requested the participation of therapists, and provided instructions for obtaining a summary of research results at the conclusion of the project. See Appendix A for the complete text of the letter.

Letter requesting distribution

In addition to the standard cover letter attached to each questionnaire, a special letter also was mailed to treatment directors in agencies where the names of individual therapists were unknown. This letter requested the directors' cooperation in distributing the questionnaire packets. See Appendix B.

Questionnaire

The stress questionnaire is reproduced in Appendix C and was composed of four sections as follows:

Section A: BACKGROUND INFORMATION consisted of seven questions pertaining to subject gender, age, educational background, job title, experience, work setting, client population, form of therapy, and number of client contact hours per week.

Section B: THERAPIST STRESS SCALE listed 19 client behaviors and 16 therapist experiences relating to the professional role. An additional item asked therapists to give a global rating of their current level of stress. Subjects were asked to rate these 36 items on a 99-point scale according to how stressful each item was to the respondent. Spaces were provided for subjects to add their own items.

Twenty-one of the total 36 items were repeats or facsimiles of items used by Farber (1978) in his stress scale. Some of Farber's statements were reworded for clarity (e.g., "apathy and depression" changed to "severely depressed client") or were rewritten as more than one item (e.g., "aggression and hostility" changed to three statements regarding verbal aggression toward the therapist, toward others, and physical aggression toward the therapist). The other client behavior and therapist experience items reflected stressors cited frequently by therapy professionals.

Client behaviors were described behaviorally or in common clinical terms. In addition, subjects were asked to record the frequency that each of these behaviors occurred in their work. Therapist experiences were less discrete and were meant to be phenomenological in tone.

Section C: THERAPIST BELIEFS requested therapists to rate 13 irrational or exaggerated statements according to

how much each one contributed to the subject's own stress. A 99-point rating scale was used. The 13 beliefs were fashioned after Forney et al.'s irrational counselor beliefs in an attempt to elucidate what, if any, cognitions may underlie therapist stress (Forney et al., 1982). Because of the psychological sophistication of the intended subjects, a straightforward and even transparent approach was used to elicit this information. Pilot work on this scale resulted in the addition of one item and refinements in wording of the instructions.

Section D: THERAPIST PROBLEMS contained three parts relating to (1) the respondent's history of personal therapy, mental health hospitalization or other treatment, (2) untreated disturbances, and (3) work days missed due to illness. Due to the sensitive nature of these questions, subjects were reassured again in the section instructions of the anonymity and confidentiality of their responses.

Postcard prompt

A postcard (Appendix D) mailed to all potential subjects three weeks after the first mailing urged return of all questionnaires and thanked those who had already complied.

Data Analyses

The dependent variables were the therapists' frequency estimates for specified client behaviors (Section B); ratings of stress for client behaviors and therapist experiences (Section B), and irrational beliefs (Section C); and responses to items about therapist problems (Section D). Independent variables were the subject background characteristics from Section A (sex, age, college degree and major, job title, experience, work setting, clientele, therapy format, and caseload size).

Means and standard deviations of stress ratings were computed for identification of relative stress levels and stress items of interest. The relationships among item ratings were explored using factor analysis. Factor scores were calculated for subject groups, and analyses of variance were performed on factors in a tentative investigation of whether groups rated items differently. Analysis of variance results and significance levels were to be considered strictly descriptive in accordance with the exploratory nature of the study and the absence of formal hypotheses.

Frequency ratings of each client behavior were averaged, and subject group trends were investigated using Pearson product moment correlation coefficients. Data on therapist problems were analyzed similarly.

RESULTS

Subjects

Six hundred and forty-two stress questionnaires were mailed to all psychotherapists identified in the state of Iowa (see Procedure). Subjects were 264 psychotherapists who returned completed, usable questionnaires. Thirteen of the initial 642 questionnaires were found to be undeliverable due to incorrect address. Of the remaining 629 forms, 310 were mailed back to the investigator as requested, for a return rate of 49%. Forty-six of these were not used in the analyses for the following reasons: college degree unspecified (9); degree specified was bachelor's level (12); subject not currently conducting therapy (5); completed questionnaire received after analysis had begun (9); and incomplete questionnaire (11). A questionnaire was rejected for being incomplete if 10% or more of the items were left blank. Of the 11 subjects in this category, two enclosed notes explaining that they did not have time to finish the questionnaire; one appeared to have inadvertently skipped one entire page; and the remaining eight left large portions blank for reasons unknown to the investigator.

The final subject sample consisted of 101 women (38%) and 163 men (62%). There were 195 Master's-level and 69 doctoral-level therapists. Eighty-five subjects had degrees

in psychology, 117 in social work, 34 in counseling, 13 in education, and 15 in a variety of other fields (e.g., theology; child development). The last three categories were combined in the data analyses, resulting in the three college major classifications of psychology, social work, and other.

Fifty-five subjects reported administrative job titles such as department head or director. The remainder (209) were in non-administrative positions, with job titles reflecting the position of psychotherapist or counselor.

For the total sample, mean values and standard deviations for other background variables are presented in Table 1. The average age was 40.65 and the average number of years' experience as a therapist was 10.11. Ages ranged from 25 to 68, while years' experience ranged from 1 to 34. Furthermore, these therapists reported an average of 75% of work time spent in agencies and 22% in private practice. Their client population was composed primarily (72%) of adults, with 25% children and adolescents. The most prevalent form of therapy was individual, comprising 59% of all time spent in therapy. The mean number of hours spent weekly conducting therapy was 24.07.

These subject characteristics are amazingly similar to those of Farber's subjects despite apparent differences in the original subject pools (Farber, 1978). Farber

Table 1. Means and Standard Deviations of Subject Characteristics

Subject characteristic	M	SD
Age	40.65	9.54
Years' experience	10.11	7.54
% time spent in private practice	22.12	37.17
% time spent in agency work	75.66	37.88
% children and/or adolescent clients	25.06	25.94
% adult clients	71.58	26.90
% time spent in individual therapy	59.44	21.95
% time spent in couple counseling	16.83	15.12
% time spent in family therapy	13.25	14.54
% time spent in group therapy	9.39	15.78
Hours per week spent in client sessions	24.07	10.17

surveyed 60 psychiatrists, psychologists, and social workers, while this study's sample included therapists with other degree specialties and excluded therapists with medical training. In addition, Farber's predominately psychoanalytic group came from an urban area in the eastern United States, contrasted with this sample's more rural Midwestern base. Farber's subjects (40% women and 60% men) had an average age of slightly over 38 and a mean years' experience of 10. Therapists reported working an average of 21 hours per week, with approximately the same breakdowns for client characteristics as those reported above for the present study. These and other similarities with Farber's subjects are important when considering the generalizability of both studies' results.

Subject groups

The subject background variables (gender, age, college degree and major, job title, experience, work setting, clientele, therapy format, and number of client contact hours per week) were the independent variables while frequency ratings, stress ratings, and therapist problem data formed the dependent variables. Additionally, subject groups were defined for conducting analyses of variance on stress data. Groups based on subject sex, college degree, and major were self-defined. In certain analyses, degree and major were combined to form a single variable called profession. The

profession variable had five levels: Master's degree in psychology, Master's in social work (MSW), Master's degree in other field, doctorate in psychology, and doctorate in other field.

Subject groups based on age, experience level, setting, clientele, and caseload were derived using logical and statistical reasoning. The age variable was split into three groups, with the young group composed of subjects less then 35 years old (n = 83), the older group of subjects 35 to 44 years old (n = 98), and the oldest group over 44 (n = 83). Farber's labels were used for the experience groups (Farber, 1978). Inexperienced therapists were defined as those with less than 4 years' experience (n = 49), early career therapists had 4 to 10 years' experience (n = 125), and experienced therapists had more than 10 years (n = 90). Subjects reporting over 50% of their work time spent in private practice (n = 55) and those reporting over 50% in agency work (n = 200) comprised the setting groups. The clientele groups consisted of subjects spending over 50% of their work time with children and/or adolescent clients (n = 34), and subjects spending over 50% with adult clients (n = 201). Finally, caseload was a subject variable based on number of hours per week in client sessions. A light caseload consisted of 15 or fewer hours per week (n = 58), a moderate caseload had 16 to 25 hours per week

(n = 113), and a heavy caseload had over 25 hours per week (n = 93).

Missing values

Twenty-three of the 264 subjects each left out responses to up to four items. These missing values were supplied by the investigator. In all cases the item means obtained from completed questionnaires, the subject's pattern of responding to similar items, and/or clinical judgment were utilized in deriving these estimated values. The greatest number of missing values for any single background item retained was seven for background item 9, which requested the subject's average number of hours per week spent conducting therapy. The greatest number of missing values for any single stress item retained was eight for the stress rating of item 6, client agitated anxiety.

One portion of the background information section apparently was confusing to respondents. Item 7 asked subjects to estimate the percent of their client population that was composed of children/adolescents, adults, substance abusers, psychotic clients, and normal/"neurotic" clients. The categories were not intended to be mutually exclusive; however, 31 subjects wrote questions or clarifying comments regarding the category overlap. Another 21 subjects failed to provide figures for the three diagnostic-type categories (substance abusers, psychotic clients,

normal/"neurotic" clients), and 29 subjects wrote in the additional diagnostic category of personality disorder. Given the substantial number of subjects who did not accept the three diagnostic-type classifications as provided, these items were dropped from further analysis. Data for the descriptive, age-related client categories (children/adolescents, adults) were retained.

After response frequencies were computed for all stress items, eight items were eliminated from further analysis due to subject response rates of less than 90%. These items and proportions of missing responses are listed in Table 2.

Score transformations

All stress ratings were made on a scale of 1 to 99 and were transformed to normal deviates using a procedure described by Wolins and Dickinson (1973). Using this procedure, a raw score of 1 becomes -2.33, a score of 99 becomes +2.33, and 50 becomes 0. Scores in the middle of the scale are compressed and those in the ends are stretched, creating a distribution that more accurately depicts the strategy typically used by subjects in making ratings. A transformed score of -2.33 corresponds to "not stressful," a transformed score of 0 corresponds to "moderately stressful," and a score of +2.33 to "extremely stressful."

Table 2. Stress Items Eliminated and Percent of Missing Responses

Stress item	% missing responses
Overt flirting (heterosexual) directed toward you	13
Overt flirting (homosexual) directed toward you	41
Bizarre gestures or postures	14
Blatantly psychotic speech	14
Suicide attempt by client	20
Physical attack on you by client	71
Client reporting current criminal activity	14
Demand by client's family or friend for confidential information	13

Relationships between independent variables

Pearson product moment correlation coefficients were computed to discover the relationships between all the continuous or dichotomous (i.e., gender, degree, and job title) background variables. In addition, dummy variables were constructed for the nominal category of college major in order to obtain correlations between major and other background variables. Special attention was given to associations between gender, degree, and major in the form of chi-square analyses for gender-by-major subject frequencies and for degree-by-major frequencies. Results of chi-square computations are shown in Table 3.

Results of the chi-square tests on gender, major, and degree frequencies suggest that the field of psychology was over-represented by males compared to females, while the reverse was true for the field of social work. It also appeared that the holders of Master's degrees were disproportionately more likely to be social workers than psychologists, and only one doctoral-level social worker was identified in the sample. This is not surprising given that the Master's generally is considered a terminal degree for applied social work.

Examination of correlations among background variables revealed that males more than females held doctoral-level

Table 3. Chi-Square Tables for Gender by Major and for Degree by Major

	Gender	
Major	Female	Male
Psychology	20	65
Social work	53	64
Other	28	34

$\chi^2 = 11.52$, df = 2, $p < .01$

	Degree	
Major	Master's	Doctorate
Psychology	41	44
Social work	116	1
Other	38	24

$\chi^2 = 72.73$, df = 2, $p < .001$

degrees ($r = .24$, $p < .01$) and administrative positions ($r = .25$, $p < .01$). Males also were more experienced as therapists ($r = .27$), although no significant correlation was found between gender and age ($r = .07$, ns).

The high correlation between age and experience ($r = .71$) was expected. Both age and experience correlated psoitively with proportion of time spent in private practice ($r = .23$ for age, $r = .22$ for experience; $p < .01$) and negatively with time in agency work ($r = -.22$ for age, $r = -.23$ for experience). Besides working more in private practice, older therapists tended to work more with adults, less with children and adolescents, somewhat more in individual therapy and less in family therapy, and to spend more hours per week in client contact than did younger therapists. Similarly, years' experience correlated positively with hours per week in client sessions ($r = .23$), indicating that more experienced therapists were spending more hours per week in therapy with clients.

The variables relating to private practice versus agency work were highly negatively correlated ($r = -.97$), as expected. Time spent in couple therapy was positively associated with private practice ($r = .25$, $p < .01$) and negatively with agency work ($r = -.30$). Also, agency therapists reported comparatively more time with children/

adolescents ($r = .17$, $p < .01$) and in individual therapy ($r = .15$, $p < .05$).

The only additional information provided by the dummy variables representing college major was that psychologists were more likely than social workers or others to work with adult clients and to conduct individual and group therapy, and less likely to work with children/adolescents and to conduct family therapy.

To summarize the relationships among subject characteristics:

1. Men were more likely than women to have doctoral degrees, to have majored in psychology, to hold administrative titles, and to be more experienced as therapists.
2. Older and more experienced therapists were found more in private practice.
3. Older therapists spent more hours per week with clients and were more likely than younger subjects to conduct individual therapy and with adults.
4. Agency workers spent proportionately more time than private practitioners working with children and/or adolescents.
5. Psychologists most often conducted individual or group therapy and with adults, while therapists from other disciplines worked more with younger

clients and in family therapy.

Again, these work patterns are remarkably similar to those of Farber's 60 subjects (Farber, 1978).

Frequency of Client Behaviors

The variable "frequency" is the frequency of occurrence of each of the 19 client behaviors. Subjects were asked to estimate in what percent of their client hours each behavior occurred. Data are reported for all client behaviors, including those eliminated from further analysis because of missing stress ratings. (Client behaviors were each given two scores by subjects: a frequency score and a stress rating.) For the purposes of frequency calculations, all items not rated by subjects for stress were assumed to have never occurred for that subject and were assigned a frequency score of 0. These values were included in computation of frequency means. Client behavior items, mean hours, and standard deviations are listed, from most to least frequent, in Table 4.

T-tests for correlated means were applied to selected pairs of frequency means. Results suggest that differences exist between scores two rank positions apart and, in some instances, one rank position apart. This lends validity to the rank ordering of frequency means.

Examination of Table 4 reveals that the most frequent

Table 4. Frequency Means and Standard Deviations for Client Behaviors Ranked from Most to Least Frequent

Client behavior	M	SD
Absence of expression of gratitude from client	38.23	28.24
Client expressions of aggression and hostility toward another person	32.75	22.76
Client agitated anxiety	30.57	22.07
Apparent apathy or lack of motivation in client	25.33	18.09
Client crying	24.48	20.01
Client's premature termination of therapy	20.25	18.90
Severely depressed client	19.98	15.72
Client giving history of victimization through rape, incest, beatings, or other severe abuse	19.90	18.15
Client late to appointment	15.33	14.25
Client expression of anger toward you	14.09	15.71
Suicidal statements made by client	11.49	10.27
Bizarre gestures or postures	8.64	13.74
Blatantly psychotic speech	8.10	14.00
Overt flirting (heterosexual) directed toward you	6.79	10.12
Demand by client's family or friend for confidential information	6.42	8.97
Client reporting current criminal activity	5.94	11.66
Suicide attempt by client	3.06	5.19
Overt flirting (homosexual) directed toward you	2.08	5.67
Physical attack on you by client	0.84	5.02

client behavior was absence of gratitude from a client. Therapists reported that, on the average, this occurred in 38% of all client contact hours. The other most frequent behaviors were the client's expression of aggression and hostility toward another (with a mean frequency of 33%), agitated anxiety (31%), client apathy or lack of motivation (25%), and crying (24%).

As discussed previously, eight stress items were eliminated from further analyses because stress ratings were missing from 10% or more of subjects. Comparison of Tables 3 and 4 shows that the items with missing stress ratings were those ranking lowest in frequency. Interpretation of statistics involving these eight items must be undertaken with caution because the investigator assumed a frequency of 0 for items left blank. While this assumption appears sound given the content of these eight items, the frequencies may be spuriously low.

Correlations were calculated between frequencies and the independent variables. The only items revealing statistically significant correlations with gender (coded: 1 = female, 2 = male) were "client giving history of victimization through rape, incest, beatings, or other severe abuse" ($r = -.17$, $p < .01$) and "suicide attempt by client" ($r = -.12$, $p < .05$), indicating that women therapists reported

these client behaviors more frequently than did men therapists.

Two frequency variables were significantly correlated with both age and experience; younger and less experienced therapists reported higher incidences of clients being late to appointments ($r = -.17$, $p < .01$, for both age and experience) and client apathy ($r = -.15$, $p < .05$, for age; $r = -.21$, $p < .01$, for experience). Frequency of absence of expression of client gratitude correlated negatively with experience ($r = -.13$, $p < .05$) but not with age ($r = -.08$, ns), indicating that more experienced therapists reported this behavior less frequently than less experienced therapists.

The client behavior items relating directly to psychotic manifestations (bizarre gestures or postures and blatantly psychotic speech) and client motivation (absence of expression of gratitude from client, client's premature termination of therapy, and apparent apathy or lack of motivation in client) were reported as occurring more frequently by agency therapists and less frequently by private practitioners. It is expected that agency therapists would in fact have more contact with severely disturbed clients and with those who are involuntarily committed to treatment and who are, therefore, less often

motivated for therapy. Psychotic behaviors also were reported more frequently by therapists spending more time conducting group therapy, by therapists working with adults, and by therapists with light caseloads. All these independent variables are positively correlated with each other and with time working in an agency. In addition, psychologists more than other professionals reported higher frequencies of symptoms of severe pathology in clients. None of the frequency scores correlated significantly with college degree.

Correlations also were obtained between frequency and the other dependent variables. The frequency scores tended to be highly and significantly correlated with each other, suggesting a response set among subjects in this portion of the questionnaire. However, frequency scores were not generally correlated with stress ratings. Eleven client behaviors were rated on both the frequency and stress measures, so correlation coefficients were available between the frequency and the stress score for those eleven items (Table 5). Only three of these eleven client behaviors showed significant correlations between frequency and stress scores; in each case, greater frequency was associated with less stress. For the majority of items, it appeared that the frequency with which a particular client

Table 5. Correlations between Frequencies and Stress Ratings for Client Behaviors

Client behavior	r
Client crying	-.12
Client expressions of aggression and hostility	-.20**
Absence of expression of gratitude from client	-.13*
Client agitated anxiety	-.07
Client's premature termination of therapy	-.01
Apparent apathy or lack of motivation in client	.02
Client giving history of victimization through rape, incest, beatings, or other severe abuse	.05
Client expression of anger toward you	-.10
Severely depressed client	-.15*
Suicidal statements made by client	-.08
Client late to appointment	.08

*Significant at the .05 level.

**Significant at the .01 level.

behavior occurred was not related to the amount of stress that it engendered in the therapist. However, extremely infrequent occurrences, such as suicide attempt or physical violence, were not included in these eleven items.

Finally, correlations between frequency and the measures of therapist personal problems were examined. The number of correlations reaching statistical significance was low given the number of variables involved. The only finding of clinical interest was the positive relationship between reported frequency of severe depression in clients and whether the therapist had experienced depression in her/his own life ($r = .16$, $p < .01$). In other words, therapists who have identified depression in themselves at one time also perceived depression more frequently in clients.

The major frequency findings are summarized as follows:

1. The most frequent client behaviors reported by this sample of therapists were absence of client gratitude, client hostility toward another person, client anxiety, apathy, and crying. These events each occurred in approximately one-quarter or more of all therapy hours.
2. Except for a very few items, subjects had similar frequency means regardless of therapist sex,

college degree, or job title.

3. Women had higher frequency means than men for two items: client giving history of victimization through severe abuse, and client suicide attempt.
4. Client apathy and lateness were reported more by younger and by inexperienced therapists. Absence of client gratitude was reported more by inexperienced therapists.
5. Percent time spent in agency work correlated positively and percent time in private practice correlated negatively with frequency of psychotic symptoms and low treatment motivation in clients.
6. Psychotic behaviors among clients were reported more by subjects conducting group therapy, by those working with adult clients, and by subjects with relatively lighter caseloads.
7. Frequency scores were positively intercorrelated but generally did not correlate with stress ratings.
8. Therapists reporting a greater frequency of depression in clients were likely to have reported experiencing depression themselves.

Stress Ratings: Client Behaviors and Therapist Experiences

Twenty-seven client behavior and therapist experience items were retained for analysis. The items and their stress means and standard deviations for the entire subject group are presented in rank order from most to least stressful in Table 6. More positive mean stress ratings indicate relatively greater stress.

T-tests on selected pairs of these correlated means revealed that items ranked four and sometimes three positions apart generally differed significantly at the .01 level.

As can be seen in Table 6, therapists considered clients' suicidal statements as the most stressful work-related occurrence. Sixty-one percent of all subjects marked this as moderately stressful or higher. Inability to help an acutely distressed client was the second most stressful item, with 59% of subjects recording a stress rating of moderate or higher. Other items for which half or more of the sample reported moderate or higher stress were: client expression of anger toward you (58%), lack of observable progress with client (50%), severely depressed client (52%), and apparent apathy or lack of motivation in client (51%). These are also the highest ranking stress items when ordered by means (refer to Table 6).

Table 6. Client Behavior and Therapist Experience Stress Means and Standard Deviations Ranked from Most to Least Stressful

Stress item	M[a]	SD
Suicidal statements made by client	- .03	.76
Inability to help an acutely distressed client to feel better	- .04	.76
Seeing more than the usual number of clients in a week	- .10	.96
Client expression of anger toward you	- .12	.72
Lack of observable progress with client	- .14	.69
Severely depressed client	- .20	.69
Apparent apathy or lack of motivation in client	- .22	.70
Not liking a client	- .32	.84
Client's premature termination of therapy	- .36	.74
Giving potentially painful interpretations or feedback to client	- .38	.75
Your doubts about the effectiveness of therapy	- .38	.69
Professional conflicts with colleagues	- .46	1.02
Client bringing up an issue that happens to be a sensitive area in your own personal life	- .47	.74
Client giving history of victimization through rape, incest, beatings, or other severe abuse	- .48	.81
Overall, about how stressed or "burned out" do you feel right now?	- .49	.76

The need to be constantly attentive in sessions	- .50	.72
Client agitated anxiety	- .52	.69
Client expressions of aggression and hostility toward another person	- .58	.80
Isolation from other professionals	- .67	1.02
Sense of responsibility for clients' lives	- .75	.88
Controlling expression of your own emotions in sessions	- .88	.67
Client crying	- .88	.75
Balancing empathy with appropriate professional distance from client	- .89	.75
Client late to appointment	- .96	.84
Inability to leave client concerns behind when you leave work	-1.00	.81
Stereotypes about therapists held by community members	-1.01	.87
Sexual attraction to a client	-1.10	.83
Absence of expression of gratitude from client	-1.23	.70

[a]More positive stress score = greater stress.

The least stressful event was absence of gratitude from client, which was considered moderately or more stressful by only 6% of the sample. The six least stressful items as determined by mean ratings were each rated moderately stressful or higher by less than 15% of the subjects.

Associations between independent variables and stress ratings were calculated using Pearson product moment correlation coefficients. Correlations with the independent variable of gender (coded: 1 = females, 2 = males) were clearly significant for three stress items: female therapists were more stressed by clients giving histories of victimization ($r = -.18$, $p < .01$) and by not liking a client ($r = =.19$, $p < .01$), while males were comparatively more stressed by sexual attraction to a client ($r = .18$, $p < .01$).

Age correlated negatively ($p < .01$) with six of the stress items, indicating that older therapists recorded lower stress ratings than younger therapists on these items. The trend for older therapists to experience relatively less stress was observed for nearly all the stress items. However, the experience variable, which was strongly associated with age, correlated significantly with only one stress item, client crying ($r = -.19$,

$p < .01$). Correlation coefficients for stress and job title generally were nonsignificant and no trends could be discerned. Exceptions were the high correlations between job title and client crying ($r = .18$, $p < .01$) and sexual attraction ($r = .16$, $p < .01$), demonstrating that administrators were more stressed by these occurrences than were subjects without administrative titles.

Correlations between stress ratings and the remaining background variables were low and generally nonsignificant with a few exceptions. Three items showed significant ($p < .01$) positive correlations with the variable representing proportion of time spent in agency work, and negative correlations with proportion of time spent in private practice. Specifically, agency therapists were more stressed and private practitioners were less stressed by clients crying, by the therapists' own doubts about therapy effectiveness, and by controlling their own emotions in sessions. None of the therapy format variables correlated meaningfully with stress ratings. As might be expected, therapists spending the greatest number of hours per week in client contact were also the most stressed by seeing more than the usual number of clients in a week ($r = .17$, $p < .01$). In addition, the more time spent weekly with clients, the less was the stress when clients

made suicidal statements ($r = -.17$, $p < .01$). No meaningful correlations occurred between stress ratings and the dummy variables constructed to represent college major.

Thirty-seven subjects added their own suggestions to the list of potentially stressful client behaviors in a space provided. These were not included in the statistical analyses. The greatest number of added items were those regarding clients lying or misrepresenting the truth to the therapist or to other people. Several symptoms of severe pathology that were not included in the original list of client behaviors were identified by several subjects as stressors, such as "patient including therapist in patient's delusional system." Extreme dependency by the client on the therapist and phone calls to the therapist's home each were mentioned by at least three therapists.

Subjects also were given the opportunity to add items that reflected stressful therapist experiences outside the actual therapy session. Of these fifteen different items added by subjects, over half dealt specifically with conflicts between clinical judgment and administrative policies or procedures. Representative of these complaints were statements about the conflicting goals of clinicians versus administrators. The most strongly worded comments

by subjects were in this category, with references to "incompetent" department heads, "ignorant" board members, and "asinine" bureaucrats. The remaining stressors added by subjects pertained to professional issues related to private practice (e.g., collecting fees), forensic involvement (e.g., courtroom testifying), and requests to fill out questionnaires.

Stress Ratings: Irrational Beliefs

Stress rating means and standard deviations for the 13 irrational belief items are listed in descending order of stress means in Table 7.

Selected t-tests for correlated means were conducted to aid in interpreting the meaningfulness of the rank ordering of irrational beliefs. Results of these tests showed that statistically significant differences exist between items ranked two and three positions apart throughout the entire list of items.

No irrational belief was considered moderately stressful or more by as much as 50% of the subjects. Forty percent or more rated the three most stressful beliefs (I should always work at my peak level of enthusiasm and competence; I should be able to handle any client emergency that arises; and, I should be able to help every client) as moderately stressful or higher. The

Table 7. Irrational Belief Stress Means and Standard Deviations Ranked from Most to Least Stressful

Irrational belief	M[a]	SD
I should always work at my peak level of enthusiasm and competence.	- .26	.88
I should be able to handle any client emergency that arises.	- .35	.83
I should be able to help every client.	- .40	.97
When a client does not progress, it is my fault.	- .51	.87
I should not take time off work when I know that a particular client needs me.	- .64	.92
My job is my life.	- .65	.87
I should be able to work with every client.	- .76	.94
I should be a model of mental health.	- .86	.86
I am "on call" 24 hours a day.	- .92	1.03
My clients' needs always come before my own.	-1.13	.93
I am the most important person in my client's life.	-1.35	.73
I am responsible for my client's behavior.	-1.35	.82
I have the power to control my clients' lives.	-1.46	.82

[a]More positive stress score = greater stress.

least stressful irrational beliefs were: I have the power to control my clients' lives; I am responsible for my client's behavior; and, I am the most important person in my client's life.

Correlation coefficients relating irrational belief stress ratings with the independent variables were calculated. Several findings were of interest for the subject sex, age, and experience variables. Females were significantly more stressed than males by the four highest scoring irrational items. The correlations for the fifth highest item was in this direction also, while the rest of the irrational items showed virtually no association with gender. The age and experience variables showed the same relationship with irrational beliefs; that is, older and more experienced therapists were less stressed than younger and less experienced therapists by the highest ranking beliefs. Client age and therapy format demonstrated no significant relationships with irrational belief stress ratings. For the background variable called caseload (number of hours per week in client contact), only the correlation with the belief "I have the power to control my clients' lives" was statistically significant, indicating that therapists seeing many clients in a week were less stressed by this belief.

Irrational beliefs were added by 29 subjects. These tended to be quite specific to a subject's work situation or were variations of the original questionnaire beliefs. Several subjects shared stressful beliefs regarding time constraints (e.g., I should work overtime without compensation) and the image of them held by others (e.g., Other professionals should see me as exceptionally competent). Again, conflicts between policy-makers and clinicians were evident in statements such as "I should be able to get along better with the administration." However, the overwhelming majority of beliefs added by subjects reflected extremely high goals or perfectionism related to helping clients.

Factor Analysis of Stress Items

Iterative principle axis factor analysis and Varimax rotation were applied to the transformed stress scores on the 41 client behavior, therapist experience, and irrational belief items. The factor loading matrix is shown in Appendix E, and the factor means, standard deviations, and items which comprised each factor are listed in Table 8. Factor items were determined using combined criteria of a high factor loading on one factor relative to the item's loading on other factors. No factor item with a factor loading of less than .43 was retained for that factor.

The items loading on factor 1 all reflected strong

Table 8. Means, Standard Deviations, and Item Composition of the Stress Factors

Factor 1: M = -1.46, SD = 2.41
Client expressions of aggression and hostility toward another person
Client giving history of victimization through rape, incest, beatings, or other severe abuse
Client crying
Client agitated anxiety
Factor 2: M = -5.72, SD = 3.40
I am responsible for my client's behavior.
My clients' needs always come before my own.
I have the power to control my clients' lives.
I am "on call" 24 hours a day.
I should be a model of mental health.
Factor 3: M = -1.45, SD - 2.83
Lack of observable progress with client
Not liking a client
Your doubts about the effectiveness of therapy
The need to be constantly attentive in sessions
Seeing more than the usual number of clients in a week
Factor 4: M = -3.05, SD = 2.54
Sexual attraction to a client
Stereotypes about therapists held by community members
Overall, about how stressed or "burned out" do you feel right now?
Professional conflicts with colleagues
Factor 5: M = -1.77, SD = 1.28
Balancing empathy with appropriate professional distance from client
Controlling expression of your own emotions in sessions
Factor 6: M = -2.55, SD = 1.74
Client's premature termination of therapy
Client late to appointment
Absence of expression of gratitude from client
Factor 7: M = -.91, SD = 1.70
I should be able to help every client.
When a client does not progress, it is my fault.

Note. Items are listed beginning with the item loading highest on each factor.

emotional arousal or upset on the part of the client. The type of emotionality represented in these four client behaviors - hostility, feelings related to severe abuse, crying, and anxiety - can be painful and intense for both client and therapist. This factor was named Client Emotionality.

Factor 2 consisted of five irrational belief statements pertaining to the burdens of therapist power, and was named Responsibility for Clients. The two beliefs loading highest on this factor (I am responsible for my client's behavior; My clients' needs always come before my own) illustrate therapist attitudes that can be patronizing and, occasionally, grandiose regarding the extent of the therapist's power over the client's life. The other three items composing this factor complete the picture of the therapist as all-important to the client's well-being.

All five items loading on factor 3 describe situations in which therapy is not proceeding satisfactorily or is taxing the therapist's energies with questionable returns. These are the times when conducting therapy feels like a "pain in the neck." The factor is called, simply, Frustrations with Clients.

Stress about professional and ethical conflicts was tapped by three of the four therapist experiences loading

on factor 4, called Professional Concerns. The overall stress item ("Overall, about how stressed or 'burned-out' do you feel right now?") also loaded high on this factor, although it is not obviously related to the particular concerns demonstrated by the other items. Perhaps the stimulus of a questionnaire on therapist stress highlighted the respondents' feelings about themselves in relation to other therapists rather than to clients and gave this item a context of professional issues. The subjects may have responded differently if asked the same question by a client in the middle of a therapy session or by a friend at the end of a work day since the point of reference then would have been different, regardless of the fact that the item asked for "overall" stress.

Therapists' difficulties in controlling their own emotions during sessions with clients appeared to be the theme of factor 5, which was named Emotional Control. The two items making up factor 5 came from the therapist experience portion of the questionnaire and were originally included to measure stress arising from counter-transference.

Factor 6 was composed of three client behaviors which seemed to demonstrate the client's failure to reciprocate

the therapist's involvement in the counseling relationship. Factor 6 was labelled Minimal Client Involvement.

The final factor, factor 7, revealed therapists' own high expectations and failures to live up to them. Competency Doubts was the name given to factor 7, which was made up of two irrational beliefs.

Associations between factors and background variables and between the factors themselves were investigated using Pearson product moment correlation coefficients and are shown in Tables 9 and 10, respectively. The factor scores, derived with unit weights, were positively correlated with each other, suggesting that a subject response set may have existed across factors. That is, subjects using one portion of the scale on one item may have tended to use the same portion on other items regardless of their absolute stress levels. Another interpretation is that individuals who are stressed due to one characteristic of their profession are similarly stressed by other job aspects.

Gender correlated negatively with Frustrations with Clients ($r = -.14$, $p < .05$) and with Competency Doubts ($r = -.20$, $p < .01$), revealing that female therapists were more stressed than males by these factors. This pattern held (although not at a statistically significant level) for Emotional Control and for Minimal Client Involvement also. The factors of Client Emotionality, Responsibility

Table 9. Correlations between Stress Factors and Subject Background Variables

Background variables	Factors 1	2	3	4	5	6	7
Gender[a]	-.02	-.06	-.15*	.02	-.10	.12	-.20**
Age	-.23**	-.15*	-.11	-.16*	-.08	-.14*	-.24**
Degree[b]	-.05	-.02	-.06	-.10	-.15*	-.05	-.05
Job title[c]	.10	.09	-.04	.09	.03	.13*	-.06
Experience	-.17**	-.16**	-.04	-.07	-.12*	-.06	-.21**
% private prac.	-.14*	-.07	-.08	-.09	-.15*	.06	-.02
% agency work	.12	.08	.09	.10	.14*	-.07	.03
% children/adol.	-.03	.06	-.02	.00	-.06	.01	.05
% adult clients	.04	-.05	.03	-.05	.04	-.04	-.01
% indiv. therapy	-.12	.09	.00	-.02	-.02	-.16*	.02
% couple couns.	.03	-.05	.02	-.01	-.06	.10	.01
% family therapy	.03	-.06	-.00	-.03	-.03	.14*	-.06
% group therapy	.11	-.06	-.03	.00	.05	.02	-.06
Caseload[d]	-.10	-.12	-.02	-.06	-.13*	-.10	-.09

[a]Female coded 1; male coded 2.

[b]Master's degree coded 1; doctorate coded 2.

[c]Counselor/therapist coded 1; administrator coded 2.

[d]Caseload = hours per week in session with clients.

*Significant at .05 level.

**Significant at .01 level.

Table 10. Correlations between Stress Factors

	Factors						
Factors	1	2	3	4	5	6	7
1	1.00	.33	.43	.45	.57	.49	.29
2		1.00	.38	.44	.43	.32	.55
3			1.00	.55	.57	.44	.48
4				1.00	.54	.40	.34
5					1.00	.46	.39
6						1.00	.43
7							1.00

for Clients, and Professional Concerns showed virtually no associations with therapist sex. There are at least two plausible explanations for the women subjects' tendency to make higher stress ratings than the men. Since this was a self-report measure, the means may represent greater self-disclosure on the part of females compared to males. In other words, women therapists may not be more stressed in their work than men but may be more willing to acknowledge the ways in which they are stressed. However, the second possibility cannot be ruled out; that is, that women are in fact more stressed, particularly by their own uncomfortable feelings about clients and by uncertainties regarding their therapeutic effectiveness.

The therapist age variable showed the greatest number of significant correlations with the factors. Five of the factors showed significant negative correlations with age ($p < .05$), and the other two factors revealed detectable but statistically nonsignificant trends in that direction. Specifically, older therapists made significantly lower stress ratings on most factor items compared to younger therapists. As expected given the age correlation, factor stress scores also tended to be negatively correlated with number of years' experience as a therapist. Four of these values reached statistical significance at the .05 level, suggesting that on the factors

of Client Emotionality, Responsibility for Client, Emotional Control, and Competency Doubts inexperienced subjects made higher stress ratings than did more experienced therapists.

The correlations between the background variables of private practice and agency work and factors revealed that agency therapists were significantly more stressed and private practice therapists were significantly less stressed by the need to control their emotions in sessions (Emotional Control). (Refer to Table 9.) Correlations with Client Emotionality showed a slightly weaker but discernible pattern of the same kind; that is, private practitioners showed relatively less stress for Client Emotionality and agency therapists showed more stress. Apparently, therapists working in mental health centers, hospitals, and other agencies were more stressed than were private practitioners by emotionality, both their own and their clients', in a client session.

Emotional Control correlated significantly with college degree, indicating that Master's-level therapists reported greater stress than did doctoral-level therapists on this factor. This association was repeated for Professional Concerns but to a nonsignificant degree. It seems reasonable to assume that Master's-level therapists might believe they are accorded less status and credibility

than doctoral-level therapists simply on the basis of the former's less weighty credentials. However, it could also be argued that clients and others might have lower expectations of someone with fewer college degrees, thus making that the less stressful position. It is noted that less educated therapists did not report greater stress due to competency concerns. That is, there was no evidence that more training and credentials resulted in greater self-confidence regarding therapeutic competence, although this possibility cannot be ruled out. The most notable finding may in fact be the absence of many differences in stress ratings between those with Master's and doctoral degrees.

No meaningful associations were discovered between factors and the variables representing client age and therapy format. There were significant negative correlations between caseload and stress for the factors of Responsibility for Clients and Emotional Control, indicating that higher stress ratings in these areas were associated with lighter caseloads. This finding is investigated further below in the presentation of analysis of variance results.

Analyses of variance

A highly exploratory attitude was assumed in additional statistical analyses of the factor data. Several

two-way analyses of variance were conducted in a tentative examination of associations between factors and background variables beyond the information provided by correlation coefficients. These analyses results are descriptive only, and significance levels should be interpreted cautiously and conservatively.

Specific subject groups were of particular interest although no hypotheses had been formulated regarding patterns of stress ratings. Because of the relatively high intercorrelations between certain background variables and the correlations of several of those independent variables with factors, results of two-way analyses had to be interpreted carefully. Promising results, especially those involving possible interaction effects, were further refined in a few summary analyses. In the summary analyses all variables correlating significantly with the factor under investigation were included in the design in order to clarify the nature of interaction effects.

The only two-way analysis of variance producing an unambiguous finding was that performed on the Frustrations with Clients factor with the between-subjects variables of age and experience. No significant main effects emerged, but the experience and age interaction was highly significant, $F\ (4, 255) = 3.81\ (p < .01)$. Examination of

these data suggests that older therapists with less than 10 years' experience are less stressed by Frustrations with Clients than are the more experienced therapists in the older brackets. It may be that older therapists have the benefit of greater maturity to deal with stress in general, and those with relatively little experience as therapists have lower expectations for clients than those with many years of experience. The combination of maturity plus lower expectations might account for the lower stress scores for these subjects.

Preliminary analyses involving factor 1, Client Emotionality, led to an analysis of variance procedure which included age, experience, setting, profession (degree and major), and clientele variables and which focused on interactions for setting and profession and for client and profession. Only the latter reached a respectable significance level, $F\ (4, 179) = 2.83\ (p < .03)$. This interaction is shown in a graph of group means in figure 1. Several groups contained fewer than five subjects, but a clear finding emerged in the greater stress among therapists with Master's-level degrees in fields other than psychology or social work in working with adults contrasted with all other profession groups. There appeared to be a general tendency for psychologists (both Master's and doctorate) to be less

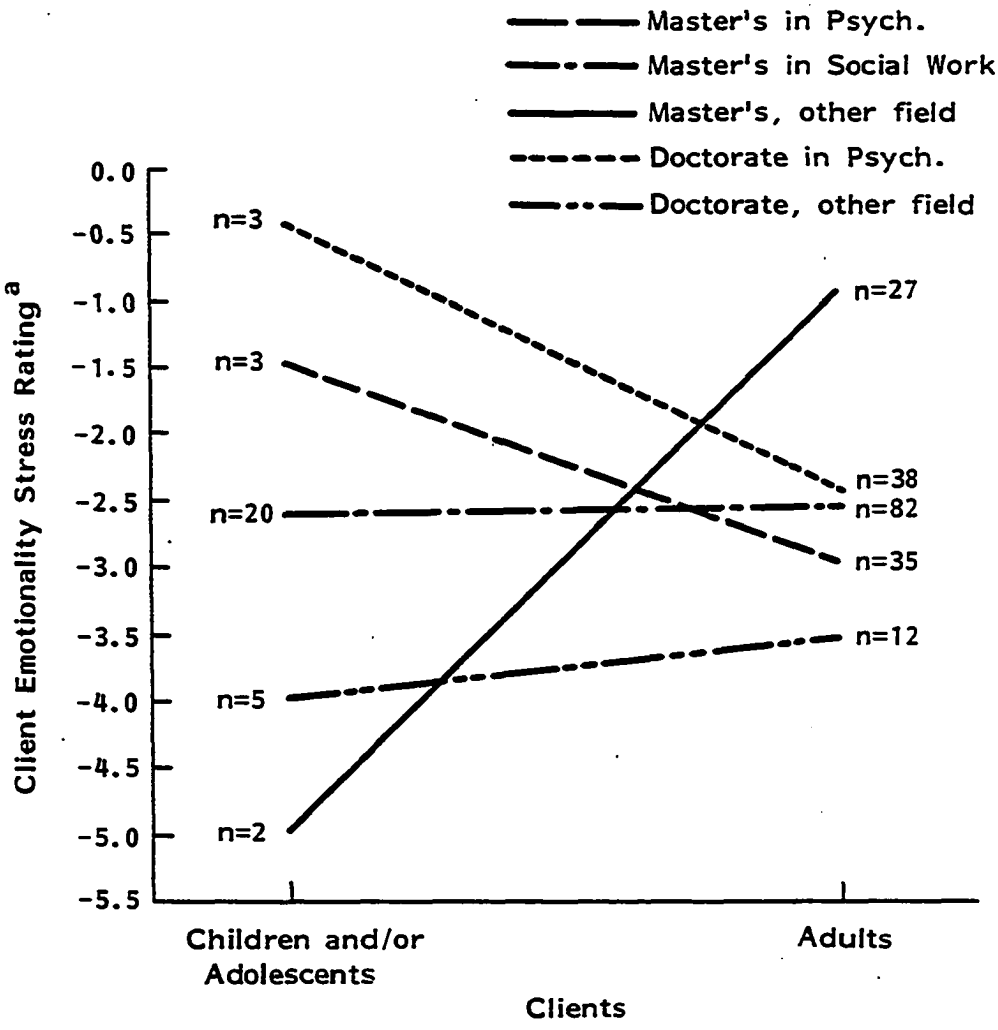
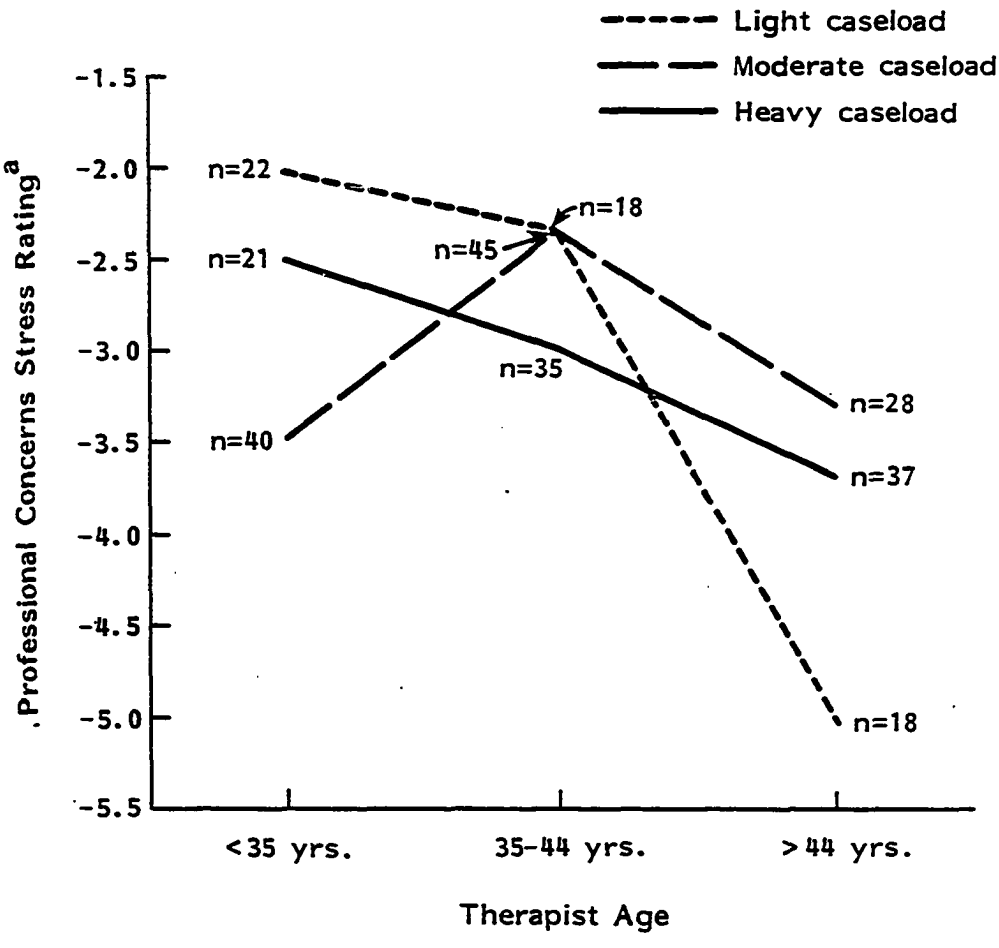


Figure 1. Client and Profession Group Means for Stress Due to Client Emotionality

stressed working with adults than with children and/or adolescents, and for therapists from other disciplines to be more comfortable with the younger clientele. Although findings are tentative, one possible explanation may be that the "other" disciplines, which include such areas as child development, family studies, and education, are more likely to be chosen by individuals whose goals are to work with children compared to therapists from a psychology background, and are areas which better prepare future counselors for handling Client Emotionality on the part of younger rather than older clients. The reverse may be true of training in psychology.

A summary analysis of variance on factor 4, Professional Concerns, included age, caseload, and experience as between-subject variables. The analysis revealed a significant main effect due to age, $F\ (2, 245) = 7.83\ (p < .001)$, and a near-significant effect for the targeted interaction between age and caseload, $F\ (4, 245) = 2.35\ (p < .06)$. As seen in figure 2, the interaction appeared to be due to the low stress mean for oldest therapists with a light caseload. That is, stress due to Professional Concerns was about the same regardless of client caseload size except for the oldest therapists with a caseload of less than 16 client hours per week, who reported much less stress. Farber (1978) also



[a]More positive stress rating=greater stress

Figure 2. Age and Caseload Group Means for Stress Due to Professional Concerns

found that a heavier caseload was not directly indicative of greater stress. His results point to setting as a mitigating variable, while the present study revealed no significant setting and caseload interactions. The caseload and age interaction effect is somewhat puzzling given that the factor involved is Professional Concerns, which is not related to caseload size in any obvious way. Again, caseload has been shown to be associated with therapist stress in subtle and complicated ways.

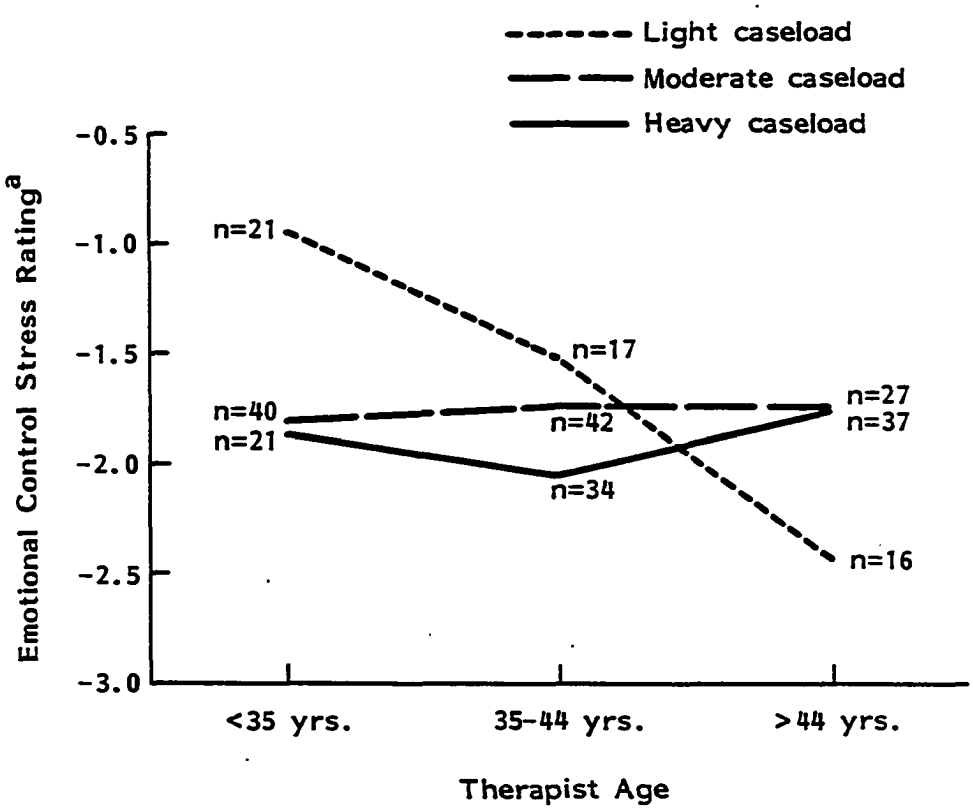
The final analysis of variance was conducted on Factor 5, Emotional Control, using the between-subject variables of age, experience, setting, profession, and caseload, and targeting the age and experience, and the age and caseload interactions. Both of these interaction effects reached statistical significance, and were the only first-order interactions to do so of all those possible. Also, there were no significant main effects in this analysis. The age and experience interaction, $F\ (4, 197) = 2.46\ (p < .05)$, indicated that therapist emotional control was differentially stressful for the three therapist age groups depending on the therapist's experience level. Further interpretation of this finding is not warranted due to low subject numbers in certain cells and the probability of a chance finding.

The age and caseload interaction for the Emotional Control stress factor revealed that a light client caseload was associated with relatively greater stress in young therapists and with relatively less stress in the oldest therapists, $F(4, 197) = 2.74$ ($p < .03$). As can be seen from figure 3, stress due to therapist Emotional Control was about equal for all ages of therapists with moderate and heavy caseloads. Young therapists were likely to be working in a setting where caseload may be assigned on the basis of the young therapist's apparent ability to handle clients. If this were true, it would then follow that caseload supervisors note the young therapists who are nervous or who lack self-confidence and assign them fewer client cases. That is, young therapists who are especially stressed to begin with may be given a lighter caseload because of that stress.

Summary of factor findings

Factor analysis and analyses of variance were conducted to further elucidate patterns in the stress data, although no formal hypotheses had been proposed. The primary results are reviewed below.

1. Seven stress factors emerged: Client Emotionality, Responsibility for Clients, Frustrations with Clients, Professional Concerns, Emotional



[a]More positive stress rating=greater stress

Figure 3. Age and Caseload Group Means for Stress Due to Emotional Control

Control, Minimal Client Involvement, and Competency Doubts.

2. Women had higher stress scores than men for Frustrations with Clients, Competency Doubts, Emotional Control, and Minimal Client Involvement.
3. In general, older and more experienced therapists had lower stress scores for all factors.
4. Client Emotionality and Emotional Control were more stressful for agency than for private practice therapists.
5. Emotional Control was a greater stressor for Master's- than for doctoral-level therapists.
6. Master's-level non-psychologists working with adult clients were more stressed than other groups by Client Emotionality.
7. Stress due to Emotional Control was highest among young therapists with light caseloads and lowest among the oldest therapists with light caseloads. A similar pattern occurred for the Professional Concerns stress factor.

Therapist Problems

The last section of the questionnaire (section D) dealt with the therapist's own personal problems. Subjects' responses to these items are described below. Data

were not analyzed beyond correlations with dependent and independent variables.

Problems and treatment

The first part of section D asked whether subjects had ever experienced certain difficulties ("occurrence"), whether they had received treatment (psychotherapy, medication, or hospitalization), and when the problem had occurred in relation to the time of professional training. The numbers and percentages of subjects responding affirmatively to each segment of this part of section D are given in Table 11.

It is noteworthy that almost two-thirds of the subjects (65%) reported that they had experienced relationship difficulties since entering training, and 125 (47% of all subjects) had sought therapy at one time in their lives for relationship problems. The figures for depression also were substantial, with 42% reporting depression since training began and 57% at some time in their lives. Over one-fourth of the sample has been in therapy for depression, and 11% has taken medication for this problem.

Although the term "depression" was not precisely defined in the questionnaire and may have been interpreted liberally by subjects, it is also tempting to speculate on a tendency for subjects to underreport their own

Table 11. Therapists' Personal Problems and Treatment Before and After Training

Problem	Occur-rence	Therapy	Meds.	Hosp.	Before trng.	After trng.
Relation-ship	217 (82%)	125 (47%)	20 (8%)	5 (2%)	103 (39%)	171 (65%)
Depression	150 (57%)	70 (27%)	30 (11%)	8 (3%)	82 (31%)	112 (42%)
Substance abuse	29 (11%)	7 (3%)	4 (2%)	5 (2%)	12 (5%)	20 (8%)
Suicide attempt	5 (2%)	3 (1%)	2 (1%)	3 (1%)	3 (1%)	2 (1%)
Other	38 (14%)	19 (7%)	11 (4%)	4 (2%)	11 (4%)	29 (11%)

Note. Percentage = % of total sample (N = 264).

problems because of fears about anonymity and because of reluctance to self-disclose such sensitive information. Thus, while the relationship and depression problem figures seem high, there is no obvious reason to doubt their accuracy.

This section of the survey stimulated many extra comments by the subjects. These were candid, highly personal, and emotionally charged. Many wrote about relationship conflicts with partners or children. They described difficulties that arose from their being therapists - the spouse or lover refusing to enter couple counseling out of fear that another helping professional would side with the therapist. Couples made up of two clinicians had unique problems of "over-processing" or "over-analyzing" their own dynamics. Several subjects wrote about loss through death or divorce and how this affected their other relationships, their families, and their work. Those who did not step out of the therapist role in times of personal crisis appeared to have the greatest difficulty resolving them. In several written remarks, subjects shared intimate facts about their families and their own disturbances.

Associations of relationship and depression data with the subject background characteristics were investigated by calculating Pearson product moment correlation coefficients.

Interestingly, while women reported more therapy involvement and medication usage than men for both relationship and depression problems, there was no sex difference in the occurrence of these problems, disregarding treatment. The correlations between gender (coded: female = 1, male = 2) and relationship problem occurrence, therapy involvement, and medication use were .03 (ns), -.14 ($p < .01$), and -.25 ($p < .01$), respectively. Similarly, gender correlated -.06 (ns) with depression occurrence, -.20 ($p < .01$) with therapy, and -.16 ($p < .01$) with medication.

For both relationship and depression problems, doctoral-level therapists (coded 2) were less likely than Master's-level (coded 1) to have had therapy ($r = -.13$, $p < .05$ for relationship problems; $r = -.12$, $p < .05$ for depression). For depression, this association also held for whether depression was experienced at all, i.e., proportionately fewer doctoral than Master's therapists reported having been depressed ($r = -.13$, $p < .05$). In addition, depression was relatively more widespread among private practitioners ($r = .19$, $p < .01$) and among therapists working with adult clients ($r = .12$, $p < .05$), and less among agency therapists ($r = -.18$, $p < .01$) and those working with children and/or adolescents ($r = -.15$, $p < .05$).

It should also be noted that relationship problem and depression occurrences correlated with each other ($r = .25$, $p < .01$), as did the variables measuring therapy involvement for both ($r = .34$). These problems are not mutually exclusive, and response independence had not been expected.

Correlation coefficients also were computed for relationship and depression occurrence with the frequency and stress items. Correlations relating to stress generally were quite low and nonsignificant. The only noteworthy finding among the problem and frequency correlations was that depression in therapists tended to be associated with more frequent reporting of depression in their clients ($r = .16$, $p < .01$), although there was no significant connection between therapist depression and stress due to client's depression ($r = -.01$, ns). Empathy for depressed clients may lead these therapists to overestimate the prevalence of the disorder in their clientele. An alternate explanation is that counselors with a history of depression are more attuned to sensing it in others.

The remaining categories of therapist problems are substance abuse, suicide attempt, and "other." Table 11 shows a substance abuse rate of 11% for this sample and a suicide attempt rate of 2%.

In the "other" category subjects specified psychosis,

anxiety, psychosomatic ailments, career worries, sexual dysfunctions, and miscellaneous other concerns. Presumably, this category was used to report disorders and treatment not listed elsewhere. If this was the case, then by making the conservative assumption that all other incidents of therapy are subsumed in the largest therapy group (relationship), it can be deduced from Table 11 that at least 54% (relationship therapy % plus "other" therapy %) of subjects have been in therapy. This is higher than Henry et al.'s (1971) figures of 41% for clinical psychologists and 30% for social workers.

Correlations with subject background variables revealed that those reporting "other" problems were more experienced ($r = .13$, $p < .05$) and worked more with adult clients ($r = .14$, $p < .05$). Substance abuse was not clearly more characteristic of any group over another.

The number of subjects in the remaining columns of Table 11 were too low for other meaningful correlations to be produced. There were no significant correlations between substance abuse or "other" problems and frequency or stress ratings.

Failure to seek therapy

The second part of section D asked whether subjects

had ever considered seeking therapy but did not do so. Ninety (34%) replied affirmatively to this "not seek therapy" item. The reasons given for not initiating therapy are listed in order of popularity in Table 12. The most commonly cited reason was that another therapist was not available whom the subject did not already know well on a personal or professional basis. Several subjects commented that there were no other therapists within reasonable driving distance or that they doubted the competence of those who were nearby. Many subjects turned to family, friends, peers, supervisors, or others for help in solving problems, or they resolved the issue themselves before therapy was necessary. There was evidence that some subjects believed that therapists should be able to solve their own problems single-handedly, since nine cited this as their reason for not seeking therapy during a difficult time in their personal lives. The individuals who mentioned distrust of confidentiality and fear of exposure generally were concerned about professional censure if their substance abuse or sexual problems were made known to others, although confidentiality worries were identified by subjects with other problems as well.

The only background variables that correlated with whether a subject had not followed-up with needed personal

Table 12. Therapists' Reasons for Not Seeking Therapy

Reason for not seeking therapy	n
No acceptable therapist nearby that I respected or didn't already know	19
Found help and support from friends, family, or co-workers	18
Problem resolved before therapy was undertaken	17
Fear of exposure; concerns about confidentiality; fear of professional censure	10
Belief that I should be able to work out problems myself	9
Didn't want to invest the energy; unwilling to put out effort	9
Cost of therapy too high	6
Spouse unwilling to cooperate in couple counseling	4
Failure to admit how serious problem was	4
Belief that therapy wouldn't help	3
Other	3

therapy were those representing percent time working in private practice and in an agency. More time in agency work was associated with an affirmative response to the "not seek therapy" question ($r = .18$, $p < .01$); a negative relationship held between private practice time and "not seek therapy" ($r = -.17$, $p < .01$). In other words, agency therapists were more likely than private practitioners to consider therapy but not follow-up.

Subjects who had considered but had not sought therapy tended to have higher stress ratings than subjects who had entered therapy when needed or who had not considered therapy. This was indicated by the finding that correlations between "not seek therapy" and 22 of the 41 client behavior, therapist experience, and irrational belief stress items reached statistical significance ($p < .05$), and all but one of the other 19 items were in the positive direction. Interestingly, the irrational belief most strongly associated with "not seek therapy" was "I should be a model of mental health" ($r = .19$, $p < .01$).

Physical illness and work absence

One hundred and eighteen subjects (or 45% of the total sample) reported having been physically ill within the previous six months. Those who were ill tended to be those who had considered but not sought therapy; illness

correlated .22 ($p < .01$) with the "not seek therapy" variable. Perhaps these are people who are hesitant to seek psychological treatment because of a stigma they believe is attached to therapists needing their own cures. The psychological/emotional ills may be unconsciously converted to physiological ones that are attended to without fear of losing face professionally. Additionally, personal problems that went untreated may have progressed to the point where severe stress resulted in physical as well as psychological symptoms. In a related finding, whether subjects had been ill correlated significantly with whether they had experienced depression ($r = .17$, $p < .01$).

An average of 1.77 days of work were missed by subjects due to illness in the preceding six months, although nearly two-thirds of the sample recorded no work days lost. Inexperienced and agency therapists lost more work time than did experienced or private practice therapists. One subject commented that he/she took time off every three to four months in order to avoid burnout and physical sickness. Another therapist jokingly suggested that "a psychosis may be indicated" by the fact that for over 20 years she/he had allowed illness only during weekends or vacation time.

Psychologists lost more work days compared to social

workers ($r = .13$, $p < .05$) and compared to other therapy professionals ($r = .12$, $p < .05$). No other background, frequency, or stress variable appeared to be associated with number of work days lost.

Illnesses listed by all subjects ranged from colds, flu, and respiratory infections to jogging injuries, severe arthritis, and cancer. Number of days missed did correlate, as expected, with whether subjects had been ill within the previous six months ($r = .31$). The only other significant correlation of interest was between number of days lost and whether the subject had experienced depression since beginning training ($r = .13$, $p < .05$).

To summarize the primary results regarding therapist disorders and treatment:

1. A majority of the sample reported having experienced depression and/or relationship difficulties.
2. Doctoral-level therapists, private practitioners, and therapists working with adult clients were less likely to have experienced depression.
3. Women were more likely than men to have received treatment for relationship problems and depression although there were no sex differences in occurrence of these difficulties.

4. Depression among therapists was associated with more frequent perception of depression in clients but not with stress due to client depression.
5. Eleven percent of the therapists admitted to substance abuse (past or present), and 7% have been in treatment for other problems not specifically mentioned previously.
6. Lack of an acceptable therapist and the utilization of existing support networks were the major reasons cited by 90 therapists for considering therapy but not following through. Subjects also expressed concern about confidentiality and the possible impact on professional standing if they revealed personal problems to other therapists. These 90 subjects were employed primarily in agencies and made higher stress ratings than other subjects.
7. Forty-five percent of the subjects were ill sometime during the preceding six months, with an average of 1.77 work days missed. Those who lost work time tended to be the less experienced therapists, the agency workers, and the psychologists. Depression was associated both with illness and with lost work time.

DISCUSSION

Mental health is an elusive variable to define and measure, yet the concept is fundamental to the profession of psychotherapy. Usually its mention is in the context of client goals and therapy outcome. Yet the therapist's own emotional and mental stability would seem to be key elements in professional success and fulfillment.

Attempts to learn what was already known about the relationship between therapist mental health and the therapy process resulted in a review of literature in several areas directly and indirectly related to the issue at hand. No more than a handful of studies was found which addressed the specific topic of therapist mental health. Discussions and studies of countertransference, the ideal therapist, client deterioration following therapy, necessary and/or sufficient therapeutic conditions, occupational stress, and therapist burnout, among other topics, had to be assimilated and integrated in order to mark the way to a research investigation of therapists' functioning in relation to their own psychological well-being. Work-related sources of stress among therapists were denoted as the point of entry for researching this uncharted territory, in recognition of the relationship between stress and mental health.

The therapist stressors to be explored were limited to

those arising from client contact and from professional role experiences, with emphasis on the phenomenological view held by the therapist. Other work-related stress sources for human service workers, such as bureaucratic inefficiency or policy conflicts, have been examined in the burnout and occupational stress literatures. In contrast, the current effort was focused on intrapsychic and interpersonal sources of stress for the professional therapist. At the same time, data on the mental health of therapists were collected from another perspective: rates of personal problems and disorders among therapists.

Before specific experimental hypotheses can be developed in this area, descriptive data should be gathered and organized. Salient dimensions can be discovered from the data and then can be controlled and/or manipulated as variables in later studies. Unfortunately, the issue of therapist stress has remained unexamined as a research topic until recently. Possible aspects of therapist stress have been proposed, discussed, and theorized about, but have rarely been systematically investigated. The goal of this project has been to solidify further the foundation for this line of inquiry; that is, to contribute to an understanding of what the salient variables are in therapist stress.

The purpose of this undertaking was threefold: to

clarify sources of therapist stress that have been introduced or speculated upon in the literature; to explore the suggestion that certain irrational beliefs are sources of therapist stress; and to determine the occurrence (self-reported) of particular disorders among the subjects. Several subject characteristics such as experience level, profession, and work setting also were thought to be significant in the existence and impact of stress, and were included in this study.

Therapist Stressors

Some of the most stressful items as determined by rank ordering of stress scores and by examination of factors related to Frustrations with Clients. Clients feeling bad or self-destructive, or not improving during the course of therapy, are stimuli for stress in the therapist. Therapists clearly are stressed by what goes on in a therapy session, and this stress has as much to do with the therapist's emotionality as with the clients'. Having uncomfortable feelings that cannot be expressed while attending to the disturbing emotions of the client are sources of potential conflict for the therapist. These professionals are purposely focused on feelings, and it is no surprise that they are highly sensitive to them personally as well.

The most and least stressful events were remarkably

similar to those uncovered by Farber with a subject population of psychoanalytic therapists (Farber, 1978). The five highest ranking client behaviors in each study are listed below to facilitate comparisons.

Deutsch	Farber
suicidal statements	suicidal ideation
expression of anger toward the therapist	aggression and hostility
severely depressed client	premature termination
apparent apathy or lack of motivation	agitated anxiety
client's premature termination	apathy and depression

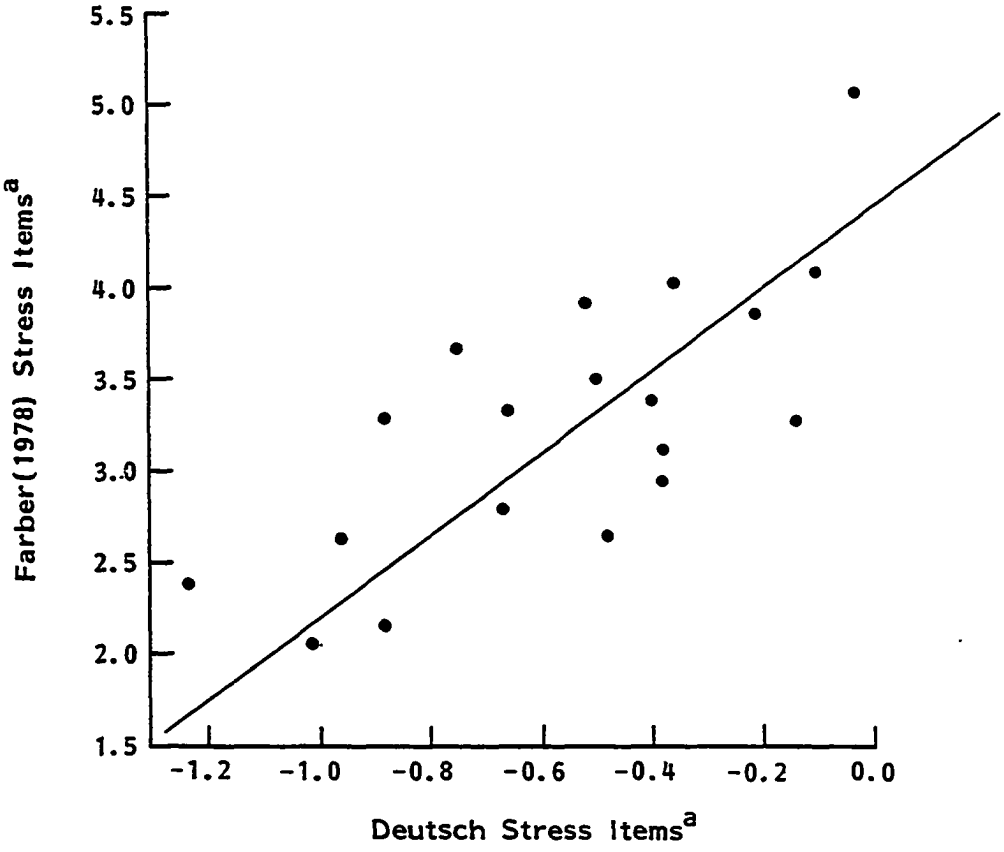
At the other end of the ranking, Farber found client crying to be the least stressful patient behavior. This study showed absence of gratitude and client crying to be the lowest rated behaviors. Farber included "absence of gratitude" in his category of stresses associated with therapeutic practice (rather than client behaviors) where it ranked among the four least stressful items, along with negative stereotypes held by community members and two other items that were not repeated in the current study. In the study reported here, community stereotypes was the second least stressful therapist experience, ranking above

sexual attraction, which Farber did not include as a potential stressor.

If the rankings of items and the classifications of stressors as patient behavior or professional experience are ignored, then the correspondence between Farber's means and the present investigator's still is striking. The means of comparable items in Farber's study (N = 60 therapists) and this one (N = 264) are depicted in the scatterplot of figure 4. Even with the different rating scales and the variations in wording of some items, the distributions of item means clearly are similar for the two studies. As can be seen in figure 4, items rated highly stressful by Farber's subjects were rated high by the Midwestern therapists, and the least stressful events also were generally agreed upon by the two samples. This concordance of findings pertaining to particular stress items lends credence to the universality of these stressors. Specific highly stressful events can be explored further in a variety of ways, with the knowledge that they are significant to therapists relative to other aspects of client sessions and the professional role.

Stressor frequencies

The client behaviors in this investigation were scored for frequency as well as for stress because that informa-



[a]More positive stress score=greater stress

Figure 4. Scatterplot of Stress Means for Similar Items from Two Studies

tion had never been compiled before, and frequency of stressful events is a relevant concern in determining overall stress within a profession. For example, both psychotherapists and school teachers may agree that suicidal statements made by their respective charges are very troublesome. However, if the therapist encounters this stressor weekly while the teacher encounters it only once in several years, then the implications for professional stress in each field are not the same. In fact, therapists reported that suicidal statements were the most stressful of all client behaviors analyzed and happened in 11% of all client contact hours, or about twice a week for the average therapist.

Since only client behaviors and not therapist experiences received frequency scores, and since several therapist experiences were among the most stressful items, no quantification can yet be done of the incidence of stress in the typical therapist's week. However, specific stressors have been identified here which affect therapists weekly if not daily.

Sexual abuse, exploitation, and attraction

Differences in stressor frequencies reported by therapists were associated generally with work setting and the types of clients found there. One exception to this was

that women therapists reported a higher frequency and a higher stress mean rating than men therapists for clients giving a history of abuse. Perhaps clients confide in a woman therapist more readily on these issues because they believe she can better identify or empathize with having been sexually abused or victimized. The same client-therapist dynamic which makes it easier for a client to self-disclose such material to a woman may also make this disclosure more stressful for the female therapist. That is, the possibility that women can empathize with this problem better than men may also be at the root of women's stress about these client issues. Women are in fact more likely to be the victims of incest, rape, and domestic violence than men (Finkelhor, 1978; Katz & Mazur, 1979; Martin, 1976) while men are more likely to be the offenders (Groth, 1979; Tsai & Wagner, 1979).

In a related matter, the sex differences in stress caused by sexual attraction to a client undoubtedly is attributable in part to the attention given in recent years to professional ethics violations when sexual acts occur between therapist and client (e.g., Hays, 1980). This attention and subsequent legal action seems to have centered disproportionately on male therapists, perhaps unfairly causing men therapists greater discomfort than women with

even the most harmless feelings of attraction to a client.

Gender-related transference and countertransference in the therapy setting apparently are quite powerful in matters of sexual exploitation and violence.

Countertransference

The presence of countertransference and possible concomitant stress have not been measured adequately here. The one stress item that overtly addressed countertransference (Client bringing up an issue that happens to be a sensitive area in your own personal life) had a stress mean in the mid-range of subjects' ranking. However, as pointed out in the review of the countertransference literature, the potentially most stressful countertransference phenomena are those that remain outside the therapist's conscious awareness. Self-report of stress arising from countertransference will tap only those dynamics of which the therapist is aware either at the time the conflict occurs in session, or in retrospect. Research is necessary in this area to supplement the on-going investigation of the association between the therapist's mental health and therapeutic efficacy. Self-report methodology has limited usefulness in this regard except in examination of intrapsychic process, i.e., what goes on inside the therapist when the client hits a nerve. Discovering that the nerve has been hit, or

identifying the sensitive areas for a particular therapist, can be better accomplished using less transparent measures.

Professional isolation

Isolation from other professionals has been named by several writers and theorists who have considered stress sources for the private practicing therapist (e.g., Bermak, 1977; Daniels, 1974). Contrary to expectations, in this study isolation actually was not rated as a major stressor by individuals working more hours privately. Perhaps it has been assumed in the past that only therapists in private practice would complain of professional isolation when in fact a feeling of professional alienation can be just as great for those employed within an institution or organization.

Irrational beliefs as stress mediators

The mechanism by which client distress elicits therapist distress is unknown, but the therapists' cognitions may provide clues. The most stressful beliefs of those explored here all reflected high energy output on the part of the therapist. Stressful beliefs are those which encourage the therapist to give out maximum levels of time, energy, and attention immediately on demand by the client. This is, of course, one definition itself of burnout.

When therapists fail to live up to their own

expectations or when the therapist-client relationship is less than ideal, then therapists feel frustrated. It is not difficult to imagine the cognitive mediator involved in this instance: failure to live up to high expectations equals personal inadequacy or even incompetence. There is only a narrow middle ground - pain or slow growth is seen as evidence of failure, and to some degree anything less than a peak effort with weekly client progress is disquieting.

The irrational beliefs generally received low stress scores relative to the other stress items (client behaviors and therapist experiences). The two questionnaire sections are not comparable in regard to ratings and use of the scale, since irrational beliefs have to be believed at some time in order to be stressful, yet at another time are labelled irrational. By taking them out of context, they have been defused somewhat, their impact lessened by the application of rational analysis. This dichotomy or change in status does not occur for client behaviors or therapist experiences. The fact that a client cries does not alter following rational examination of the event, but an irrational belief does. The latter is stressful only when it is held to be the truth; a belief that is openly identified as irrational is by definition not true, or is at best an exaggeration of the truth. A client's

crying does not in essence change when named (although certain cognitions about the event may change). Cognitions or professional myths would best be explored more subtly, or in vivo, or operationalized with behavioral correlates.

Group differences in stress

The subject characteristic of age is strongly and consistently associated with stress. It is possible that the most highly stressed therapists leave the field while they are still young. However, this argument is more convincing for the relationship between lower stress and greater experience rather than greater age per se. When viewed as a matter of ideals versus reality and coming to grips with one's own limitations, it is clearer why the older therapist is less stressed. She or he is no longer out to save the world, having found a workable balance between ideals and reality. These older professionals have resolved some of the disillusionment observed by Cherniss (1980) in novices.

Stress due to emotional arousal within a client session is more prevalent among agency than among private practice therapists. Organizational characteristics have been recognized as contributors to employee stress, and human services are no exception. However, this study intentionally excluded those obvious agency characteristics such as time spent in non-therapy job duties and decision-making

administrative responsibilities that affect many other staff members. But for agency workers, certain non-agency matters, specifically client emotionality and therapist emotional control, are major determinants of stress levels.

Control may be the crucial element for the agency therapists. Subjects' written comments centered on conflicts with administration and lack of clinical control over policy-making. Individuals who feel powerless within an organizational system may be more attuned to control needs within the therapy session. The bureaucratic hassles are out of the therapist's control; in an attempt to re-establish a greater sense of personal potency, the control issue moves to a more manageable arena. When emotions in session threaten to become chaotic, stress is triggered which actually belongs to the agency rather than to the therapeutic session.

Women therapists reported greater stress than men on most items and factors. Farber discovered this trend also (Farber, 1978). The women's frequency scores were not elevated compared to men's, so a response set for using scale extremes in self-report is not consistently evidenced. If the frequencies are accurate, then female therapists do not generally experience stressors more often than males. Are women more stressed by the same frequency of the same

events as men? Is their baseline level of stress higher, or are they more sensitive to their own discomfort and do they emphasize it in relation to their normal level of functioning? Are they more aware of their own stress, or simply disclose it more openly than men?

The women in this sample did not report greater incidence of personal problems or illness than men - yet the women did seek therapy to a much greater degree. Perhaps admitting to being stressed by challenges that are found on the job is in some way like acknowledging that one has participated in therapy - both are evidence of human frailty. Women admit to daily stress and to seeking help for problems; men acknowledge problems but not so much on a daily basis and not that they cannot solve themselves.

On the other hand, perhaps these women are under more stress than the men, and their decision to enter therapy is based on greater need. But if women are more vulnerable to stress, why don't they report more illness or sick leave than men? It is easy to dismiss the higher means for women as an indicator only of certain response tendencies. But the fact remains that, overall, only their stress means were higher than men's.

Few subject differences in stress ratings were found which were due to professional discipline or degree.

Credentials may have something to do with stress arising from client or therapist emotionality, but setting is at least as important according to these data. Again, the age and years' experience variables seemed so powerful that they overshadowed other group distinctions.

Therapist Problems and Treatment

Men and women therapists experienced personal problems equally, according to these findings, although women more frequently received therapy and medication. Depression occurrence was associated more than any other problem with certain subject characteristics and with physical illness. Depression is harder to compartmentalize in one's life than other psychological disorders - drug use can be hidden and marital conflicts kept separate from work, but depression is less amenable to confinement. A physiological component further complicates the picture - is depression a result of physical illness or a cause or a psychological concomitant? That certain subgroups reported a higher occurrence of depression is of interest in describing the problem and the population, but explanations must await further research.

Several subjects revealed problems for which they did not seek treatment for fear of professional sanction. Individuals suffering from depression or anxiety saw this as a personal flaw that was permitted in most people but not

in psychotherapists. Those with sexual concerns or alcohol or drug abuse wrote of their isolation or their long-standing denial of these problems out of fear that exposure might cost them their jobs or even their career. However, not one subject reported having been "punished" for admitting their concerns to another professional, or knew of any breaches of confidentiality. The fear of public exposure and censure because of professional standing seems to be greater than the reality.

Whether individuals have been in therapy or not may tell us less about their stress level than whether they needed therapy but did not seek it. The individuals in the latter category, primarily agency therapists, were a higher risk group both for stress and for physical illness. Because therapists employed in large social service agencies may be colleagues with most other therapists in the geographical area, it is logical that they would have a harder time identifying a therapist for themselves with whom they did not have other connections. They seem to be paying a price for their inability to obtain services, although solid conclusions are premature at this time. The comparison group consisted of individuals who had never considered and never sought therapy, and individuals who had been in therapy. However, a new avenue of approach is indicated here in

the on-going investigation of therapists and their own personal therapy.

Limitations of the Study

With self-reports, one always runs the risk of measuring only cognitions and only those considered socially appropriate by the subject group. However, it is assumed that cognitions (and even censored cognitions) have some correspondence to behavior. This assumption is strengthened when the subjects are knowledgeable and sophisticated about the relation between thoughts and behavior, such as is the case with a population of professional psychotherapists. The cognitions themselves are significant research targets when the topic being studied is something as subjectively experienced as stress. Phenomenology is relevant.

Knowing what therapists believe to be stressful to them is only the beginning. The relationship between stressors and frequency of their occurrence remains obscure; a formula for predicting stress is unknown. And while information has been provided which describes differing stress patterns between subject groups, it is merely descriptive, and inferences are severely limited.

The data on therapist disorders need to be refined in order to assess the needs of therapists in maintenance of their own mental health. It is unknown to what extent

these disorders were exacerbated or even caused by professional pressures.

Applications and Future Research

Now that research data are being generated which expand the previous speculations about therapist stress, the relevant dimensions can be further clarified and explored. Both the stress responses of therapists and their coping strategies can be investigated using the stimuli of known stressors. Analogs and actual video or audio tape recordings can be utilized to obtain data on behavior responses to stressors.

Developmental process studies advocated by Cherniss (1980) are called for given the importance of age and experience levels in therapist's reactions to stress. The results could be of particular interest to training programs. The experience that will aid the novice therapist in overcoming stress can be provided to some extent during training. Applied clinical work is part of most therapy training programs, and experience may be one of the best teachers for therapy skills in general (Henry et al., 1971) and for learning to cope with work-related stress. This experience in stress management could be provided by augmentation of existing training practica with specific experiences unique in their contributions to therapist stress. For

example, a greater focus on responding to suicidal statements made by clients or on the dynamics of power which underlie sexual abuse and which may provoke intense feelings of identification in the therapist. Another category of frequently occurring behaviors which generally frustrate younger therapists is low client motivation for therapy.

One assumption of the above suggestions is that stress interferes with the therapy process or with the therapist's well-being. This has not been proven conclusively, and as some subjects in this survey pointed out, stress can be facilitative and stimulating. So, while strategies for coping with stressful events are delineated, the desirability of reducing the therapist's stress level must be questionned. There may be an optimum level of stress which the therapist perceives as excitement, challenge, and a sign of progress. The crucial question in terms of professional standards is whether the therapist's behavior which results from his or her stress is conducive or detrimental to client growth.

Burnout researchers acknowledge that organizational, client, and therapist personality variables all contribute to emotional and psychological fatigue (Streepy, 1981). The relationship between specific therapist stressors and burnout should be more thoroughly investigated. Cognitions are

likely to be powerful mediators in that relationship, and their role in therapist stress is still unclear. The irrational belief stress results from this study are encouraging for more research in this area, as originally suggested by Forney et al. (1982).

Professional associations of mental health practitioners can make use of data on therapist disorders to aid in determining how therapists might best help other therapists. They might also consider whether a problem exists in their locale with therapists not being able to find a personal counselor with whom they are not already associated in some other way. Talking openly about the human vulnerabilities of therapists can help in several ways. For one, therapists who do anticipate support rather than professional embarrassment are more likely to seek help when they need it.

Summary and Conclusions

It is hoped that this study has helped to clarify work-related sources of stress among psychotherapists. Angry, distressed, and suicidal clients do have impact on helping professionals, and therapists from a variety of educational backgrounds and employment settings agree to a large extent on what is most stressful. Although this survey dealt with in-session and professional role concerns,

organizational conflicts and stressors were remarked on by many subjects. Certain myths or cognitions also contribute to the therapist's stress level, particularly in the case of beliefs that one should operate at peak efficiency and energy at all times, with all clients. Older and more experienced therapists generally feel less stressed than younger therapists and those new to the field. Stress due to both client and therapist emotionality may be greater for therapists working primarily in agencies rather than in private practice. Other therapist characteristics that differentially relate to stress from a number of specific sources are therapist sex and size of client caseload.

Therapists are willing to disclose personal problems when confidentiality or anonymity is assured, and they frequently utilize therapy, most often for resolution of relationship conflicts and for treatment of depression. A significant proportion are hesitant to seek therapy because of professional "complications," i.e., they cannot find a therapist nearby whom they do not already know in another context. These individuals reported more stress than others in this study.

These findings may be of interest to training program personnel to aid in preparing new therapists for the field and in addressing the needs of experienced therapists

through continuing education. It is hoped that those in mental health professions are talking more openly about occupational stress now following publication of several books on the topic of burnout in the human services (e.g., Farber, 1982; Freudenberger, 1980; Paine, 1982; Pines & Aronson, 1981), and further attention within the profession to the personal problems of therapists can explode the myth that therapists can or should be supremely healthy to the point of perfection in order to be effective in their work.

The tasks of future researchers are to examine further the relationships between therapist stress and burnout; to define and measure behavioral correlates of therapist's in-session stress; to delineate coping strategies used in response to stress; to investigate the role of distorted cognitive mediators and/or irrational beliefs in perpetuating stress among psychotherapy professionals; and, to assess the avenues by which impaired therapists receive needed treatment.

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APPENDIX A

Cover Letter

IOWA STATE UNIVERSITY

Student Counseling Service
Ames, Iowa 50011
Telephone: 515-294-5056

January 1983

Dear Colleague:

Those of us in the field of psychotherapy know that it can be both a deeply satisfying and a personally demanding profession. We share our conflicts with each other informally and in our own personal therapy, but it has been only recently that researchers have begun systematically to investigate stress among psychotherapists. Such research knowledge can be valuable to practicing therapists, to therapists who work with other therapists as clients, to consultants, and to educational and training programs that are preparing students for the profession.

We are conducting a survey of psychotherapists with Master's or doctoral degrees in non-medical fields. We are requesting your participation in this research project to add to the store of knowledge about therapists' stresses and other aspects of their mental and emotional well-being. The total time commitment on your part would be only the time it takes to fill out the enclosed questionnaire - approximately 20 to 30 minutes. Won't you take a few moments now to fill out the questionnaire and aid us in our research? Your responses are anonymous, and background information (such as gender and type of work setting) is confidential and will not be reported individually. A stamped, addressed envelope is provided for returning the completed questionnaire.

A summary of the results of this study should be available by the summer of 1983. If you would like a copy of the summary, you may call or write Ms. Deutsch at the Iowa State University Student Counseling Service.

Thank you.

Sincerely,

Connie Deutsch

Connie Deutsch, M.S.
Counseling Psychologist, and
Doctoral Candidate

FH Borgen

Frederick Borgen, Ph.D.
Professor of Psychology

Encl.

APPENDIX B

Letter Requesting Distribution

IOWA STATE UNIVERSITY

Student Counseling Service
Ames, Iowa 50011
Telephone: 515-294-5056

January 1983

Dear Colleague:

We are conducting a survey of stress among psychotherapists. Enclosed are several copies of a questionnaire and cover letter which explains our project. Stamped return envelopes are included also. Please distribute these materials to therapists on your staff who hold Master's or doctoral degrees in relevant, non-medical fields. If there are not enough surveys for all the therapists who wish to participate, copies of the blank questionnaire can be made, or you may call the Iowa State University Student Counseling Service to request additional forms.

We believe the questionnaire cover letter will answer any questions you may have at this time. If not, feel free to contact Ms. Deutsch at the Counseling Service.

Thank you.

Sincerely,

Connie Deutsch

Connie Deutsch, M.S.
Counseling Psychologist, and
Doctoral Candidate

FH Borgen

Frederick Borgen, Ph.D.
Professor of Psychology

Encls.

APPENDIX C

Stress Questionnaire

Section A: BACKGROUND INFORMATION

Please provide the following background information. Your responses are for use in statistical analyses and will not be used to identify you personally.

1. Gender: ___female ___male 2. Age: _____

3. College degree and major: _____

4. Current job title: _____

5. Number of years experience as a psychotherapist, post-Master's degree (or equivalent advanced training), half-time or more: _____

6. Approximately what percentage (%) of your time as a therapist is spent in each of the following settings:

	%
private practice	____
agency or institution	____
other: _____	____

7. Approximately what percentage (%) of your client population is composed of each of the following:

	%
children &/or adolescents	____
adults	____
substance abusers	____
psychotic (acute & chronic)	____
normal &/or "neurotic"	____
other: _____	____

8. What percentage (%) of your time conducting therapy is spent in each of the following forms of therapy?

	%		%
individual	____	group	____
couple	____	other	____
family	____	(Specify "other"	_____)

9. On the average, how many total hours per week do you spend in session with clients, in all forms of therapy combined? _____

Section B: THERAPIST STRESS SCALE

Each of the following statements describes a client behavior or experience that is unique to the therapist role. Read each item and rate how stressful it is for you personally when it occurs on an "average" day. Stress ratings are to be made using any number from 1 to 99 according to how stressful the item is, as follows:

1	10	20	30	40	50	60	70	80	90	99
not stressful					moderately stressful					extremely stressful

To the right of the stress rating for each client behavior, estimate in what percentage of client hours that particular event occurs. For example, if "inappropriate laughter" was listed and you believe that this behavior occurs in about one out of five of all your client hours, you would record "20" (for 20%) in the "% hrs" column. It is recognized that these figures will be rough averages. Write "NA" if the event has never occurred in your work. For therapist experiences (items 21-37) and question 38 you will be making stress ratings only.

Client behaviors	Stress rating	% hrs
1. client crying	____	____
2. overt flirting (heterosexual) directed toward you	____	____
3. overt flirting (homosexual) directed toward you	____	____
4. client expressions of aggression and hostility toward another person	____	____
5. absence of expression of gratitude from client	____	____
6. client agitated anxiety	____	____
7. client's premature termination of therapy	____	____
8. apparent apathy or lack of motivation in client	____	____
9. client giving history of victimization through rape, incest, beatings, or other severe abuse	____	____
10. bizarre gestures or postures	____	____
11. client expression of anger toward you	____	____
12. severely depressed client	____	____
13. suicidal statements made by client	____	____
14. blatantly psychotic speech	____	____
15. suicide attempt by client	____	____
16. client late to appointment	____	____

(continued on next page)

1 10 20 30 40 50 60 70 80 90 99
not stressful — moderately stressful — extremely stressful

Client behaviors	Stress rating	% hrs
17. physical attack on you by client	____	____
18. client reporting current criminal activity	____	____
19. demand by client's family or friend for confidential information	____	____
20. other: _____	____	____
_____	____	____

Therapist experiences	Stress rating
21. the need to be constantly attentive in sessions	____
22. your doubts about the effectiveness of therapy	____
23. controlling expression of your own emotions in sessions	____
24. professional conflicts with colleagues	____
25. giving potentially painful interpretations or feedback to client	____
26. inability to help an acutely distressed client to feel better	____
27. client bringing up an issue that happens to be a sensitive area in your own personal life	____
28. balancing empathy with appropriate professional distance from client	____
29. inability to leave client concerns behind when you leave work	____
30. sexual attraction to a client	____
31. stereotypes about therapists held by community members	____
32. seeing more than the usual number of clients in a week	____
33. not liking a client	____
34. isolation from other professionals	____
35. sense of responsibility for clients' lives	____
36. lack of observable progress with client	____
37. other: _____	____
38. Overall, about how stressed or "burned out" do you feel right now? (Use the 1-99 scale, where 1 = not stressed, and 99 = extremely stressed.)	____

Section C: THERAPIST BELIEFS

Sometimes we hold irrational or exaggerated beliefs that we generally know are not entirely true, but which nevertheless contribute to our own stress. Below are 13 statements of such beliefs. Read each one and indicate how much you think the belief contributes to your own stress, regardless of whether you rationally agree with it. Use any number from 1 to 99 according to the following scale:

1	10	20	30	40	50	60	70	80	90	99
does not contribute to stress					moderate contributor to stress					major contributor to stress

Irrational/exaggerated beliefs	Stress rating
1. My job is my life.	_____
2. I should be able to help every client.	_____
3. I should always work at my peak level of enthusiasm and competence.	_____
4. When a client does not progress, it is my fault.	_____
5. I should be able to handle any client emergency that arises.	_____
6. I am the most important person in my client's life.	_____
7. I should be a model of mental health.	_____
8. I should be able to work with every client.	_____
9. I should not take time off work when I know that a particular client needs me.	_____
10. I am "on call" 24 hours a day.	_____
11. My clients' needs always come before my own.	_____
12. I am responsible for my client's behavior.	_____
13. I have the power to control my clients' lives.	_____
14. other: _____	_____

Section D: THERAPIST PROBLEMS

The items below are included in order to gather information on incidence rates of problems and treatment of therapists as clients. Please note again that this entire questionnaire is anonymous and there is no way that your answers can be traced to you, nor do we wish to do so. Your cooperation in responding to these sensitive items is appreciated.

1. For each problem listed below, place a ✓ in the appropriate column to the right to indicate if you personally have experienced the problem (exp), if you entered therapy for that problem (ther), if you took medication (med), and/or if you were hospitalized (hosp). Also note whether the problem occurred before or after you entered training to become a therapist (mark both columns if applicable).

					When?	
Problem	exp	ther	med	hosp	before trng	during or after trng.
relationship or family problems	___	___	___	___	___	___
depression	___	___	___	___	___	___
substance abuse	___	___	___	___	___	___
suicide attempt	___	___	___	___	___	___
psychosis	___	___	___	___	___	___
other: _____	___	___	___	___	___	___

2. Since you have been a therapist, you may have had problems for which you seriously considered seeing a therapist but did not do so. If this has occurred for you, briefly describe the problem and why you did not seek therapy:

3. What physical illnesses have you had in the past 6 months, and about how much (if any) work time did you lose for each one?

PLEASE FEEL FREE TO USE THE BACK OF THE QUESTIONNAIRE TO ELABORATE ON ANY OF YOUR RESPONSES.

APPENDIX D

Postcard Prompt

Dear Colleague:

A short time ago you received a letter and questionnaire relating to stress among therapists. This is a reminder that your completed questionnaire is important to the outcome of our study. If you have already mailed back the questionnaire, THANK YOU. If not, please take a few moments now to do so. It's not too late, and we greatly appreciate your participation! Write or call if you have lost (or tossed) the original materials and would like more.

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APPENDIX E

Table 6. Client Behavior and Therapist Experience Stress Means and Standard Deviations Ranked from Most to Least Stressful

Stress item	M[a]	SD
Suicidal statements made by client	- .03	.76
Inability to help an acutely distressed client to feel better	- .04	.76
Seeing more than the usual number of clients in a week	- .10	.96
Client expression of anger toward you	- .12	.72
Lack of observable progress with client	- .14	.69
Severely depressed client	- .20	.69
Apparent apathy or lack of motivation in client	- .22	.70
Not liking a client	- .32	.84
Client's premature termination of therapy	- .36	.74
Giving potentially painful interpretations or feedback to client	- .38	.75
Your doubts about the effectiveness of therapy	- .38	.69
Professional conflicts with colleagues	- .46	1.02
Client bringing up an issue that happens to be a sensitive area in your own personal life	- .47	.74
Client giving history of victimization through rape, incest, beatings, or other severe abuse	- .48	.81
Overall, about how stressed or "burned out" do you feel right now?	- .49	.76

T35	.26	.37	.29	.20	.23	.22	.21	.47
T36	.11	.20	.64	.11	.07	.26	.32	.65
T38	.16	.20	.23	.48	-.05	.03	.10	.36
I1	.18	.44	.06	.34	-.02	.01	.09	.36
I2	.10	.42	.17	.08	-.02	.19	.70	.75
I3	.15	.44	.27	.20	.13	.07	.37	.48
I4	.08	.38	.28	.03	.14	.23	.63	.70
I5	.17	.50	.25	.17	.14	-.02	.41	.56
I6	.09	.65	.11	-.01	.39	.09	.05	.61
I7	.20	.56	.20	.16	.22	-.04	.03	.47
I8	.02	.49	.13	.18	.05	.17	.43	.50
I9	.14	.54	.12	.28	-.06	.06	.17	.44
I10	.06	.57	.09	.27	-.18	-.03	.11	.46
I11	.16	.77	.03	.17	-.14	-.02	.11	.68
I12	.10	.79	.07	-.01	.21	.30	.09	.78
I13	.05	.61	.01	.09	.18	.23	.16	.50

[a]B items = client behaviors; T items = therapist experiences; I items = irrational beliefs.

[b]Communality.